AR ADC — MEDICAL PATIENT TREATMENT RECEIVED — PAGE: 1 of 233

REPORT NO. CHSR165 - 14 — PROCESSED: 02/07/2018 09:22 AM

FROM: 02/01/2016 TO: 02/07/2018 REQUESTOR: Lorene Claibourne

NAME: Shipp, Craig Alan ADC#: 660878 SSN:

RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
02/01/2016 at: 12:47 PM	**TYPE:** HIV Intake Testing **LOCATION:** SW AR CCC **STAFF NAME:** Brown, Nadia **SETTING:** Health Services Office
	S **NOTES:** Received resident from Crawford County with current precriptions and a current MAR. Medications review and sent back with transporting Officer, but kept the current MAR. Amlodipine 10 mg po daily; Lisinopril 40 mg po daily; Pravastatin 20 mg po daily; Metformin 500 mg po bid. Called to speak with Unit MD Dr. Floss to report residents medication to receive orders to continue.
	O **NOTES:** No acute distress noted. Resident has two large knots noted to right foot, and has his left great toe amputated due to Diabetes. Resident states he is suppose to wear a shoe that was prescribed to him by the doctor, but the county would not allow him to bring it. Resident states if he does not have it withing a couple of days he is going to have to possibly go to the hospital. This nurse advised resident to write a request to the Warden regarding his personal shoes. This nurse will pass this information on to my supervisor for further reference.
	A **NOTES:** Two large knots noted to right foot, and left great toe amputated due to Diabetes.
	P **DRUP PRESCRIPTION:** Metformin Hcl Tab **DOSAGE:** 1 **STRENGTH:** 500MG **FREQ:** Twice Daily **FOR:** 30 **DAYS** **ROUTE:** By Mouth **METHOD:** Daily Dose # **REFILLS:** 0 **EXPIRATION DATE:** 03/02/2016 **DRUP PRESCRIPTION:** Amlodipine Besylate Tab **DOSAGE:** 1 **STRENGTH:** 10MG **FREQ:** Every Morning **FOR:** 30 **DAYS** **ROUTE:** By Mouth **METHOD:** Daily Dose # **REFILLS:** 0 **EXPIRATION DATE:** 03/02/2016 **DRUP PRESCRIPTION:** Lisinopril Tab **DOSAGE:** 1 **STRENGTH:** 40MG **FREQ:** Every Morning **FOR:** 30 **DAYS** **ROUTE:** By Mouth **METHOD:** Daily Dose # **REFILLS:** 0 **EXPIRATION DATE:** 03/02/2016 **DRUP PRESCRIPTION:** Pravastatin Sodium Tab **DOSAGE:** 1 **STRENGTH:** 20MG **FREQ:** Every Evening **FOR:** 30 **DAYS** **ROUTE:** By Mouth **METHOD:** Daily Dose # **REFILLS:** 0 **EXPIRATION DATE:** 03/02/2016 **LAB TEST ORDERED:** Hemoglobin A1c/hemoglobin total in blood RPR Panel 083824 PPD Test for TB **APPT SCHEDULED FOR:** Lab **ON:** 02/11/2016 **AT:** 01:18 PM **WITH:** Lab **ON:** 02/11/2016 **AT:** 01:19 PM **WITH:** Lab **ON:** 02/11/2016 **AT:** 01:20 PM **WITH:** **NOTES:** None
	E **NOTES:** None
	STANDARD FORM(S) Lab Test Order **DATE PREPARED:** 02/01/2016
	SCORE: **P:** **U:** **L:** **H:** **E:** **M/H:** **DNTL:** **F:** **B:** **D:**
	RESTRICTION NOTES: None
	REVIEW NOTES: ok

EXHIBIT A

ARKANSAS DEPARTMENT OF CORRECTION

Health History Form

MSF-101

Name: Shipp, Craig A. ADC#: 660878 DOB:

PART A - IMMUNIZATION HISTORY

	Yes	No	Date
1. Tetanus	●	○	
2. Diphtheria and Tetanus	●	○	
3. Polio	●	○	
4. Hepatitis B	○	●	

PART B - FAMILY HISTORY

		Cause of Death
Father	Alive ○ Dead ●	heart failure
Mother	Alive ● Dead ○	
Siblings	#Alive: 6 #Dead:	

PART C - FAMILY HISTORY OF DISEASES

Do you have any family history of?	Yes	No
1. Diabetes	●	○
2. Tuberculosis (TB)	○	●
3. Heart Disease	●	○
4. High Blood Pressure	●	○
5. Cancer	●	○
6. Diseases of the blood Sickle cell anemia, hemophilia etc.	○	●
7. Deafness in the family	○	●
PART E - DRUG USE - PAST or PRESENT	Yes	No
1. Steriods, Anabolic	○	●
2. Tuberculosis (TB) Medication	○	●
3. Tranquilizers and/or sedatives	○	●
4. Insulin or tablets for diabetes	●	○
5. Digitalis or heart medication	○	●
6. High blood pressure medication	●	○
7. Anticoagulants (blood thinner)	○	●
8. Glaucoma medication	○	●
9. Alcohol	●	○
10. Tobacco Number of packs per day: 0	○	●
11. Have you ever used any of the following?		
a. Barbituates (downers)	○	●
b. Amphetamines (uppers)	●	○
c. LSD (psychedelic drugs)	○	●
d. Heroin	○	●
e. Marijuana (pot)	○	●
f. Other Opiates	○	●
g. Mescalin	○	●
h. Inhalation of toxic vapors (Sniffing)	○	●
12. Have you ever used the		

PART D - OBSTETRIC/GYNECOLOGICAL HISTORY - WOMEN ONLY

HEALTH SERVICE (MD/PA/RNP/RN/LPN) COMMENTS

Part C #1) father, sister #3) father #4) father #5) grand parents
Part E #4) take metformin #6) take lisinopril and amlodipine #9) started at age 16 yrs, last intake 3 days ago #11b) started at age 18yrs, last intake 8 yrs ago
Part G #1) onset 18 yrs, due to alcohol intake #2) onset 18 yrs, due to drinking #3) onset 18 yrs, due to drinking #9) dx'ed with high BP 6 yrs ago #20) feet, due to charcot joint #21) right foot arch and bottom of feet, left foot left great toe amputated
Part I) dx'ed with diabetes 6 yrs ago and high BP dx'ed 6 yrs ago. started dipping 15 yrs, last intake 2 days ago

drugs listed in #11 intravenously? (By I.V.)	○	○

PART F - CURRENT MEDICATION or TREATMENT	Yes	No
a. Currently on any kind of medications?	○	○
b. Receiving any kind of ongoing treatment?	○	○

If yes, explain below.

Lisinopril
amlodipine
metformin 500mg bid
pravachol

PART G - SYSTEM REVIEW

Have you ever had or do you now have	Yes	No
1. Periods of unconsciousness	○	○
2. Blured vision	○	○
3. Double vision	○	○
4. Chest pain	○	○
5. Difficulty breathing	○	○
6. Difficulty hearing	○	○
7. Tuberculosis	○	○
8. Wheezing or Asthmatic attacks	○	○
9. High blood pressure	○	○
10. Diabetes	○	○
11. Coughing up blood	○	○
12. Stomach diseases (ulcers, etc)	○	○
13. Liver disease or hepatitis (Jaundice)	○	○
14. Gallbladder disease or gallstones	○	○
15. Vomit blood	○	○
16. Black (tarry) bowel movements	○	○
17. Veneral disease (syphisis, gonorrhea)	○	○
18. Frequent and/or painful urination	○	○
19. Kidney stones or blood in the urine	○	○

	Yes	No
20. Swollen and painful joints	○	○
21. Bone, joint or other deformities	○	○
22. Recurrent back pain	○	○
23. Paralysis (including infantile)	○	○
24. Frequent thoughts of suicide	○	○
25. Epilepsy or seizures	○	○
26. Depression or excessive worry	○	○
27. Nervous trouble	○	○
28. Allergic or adverse reactions to serums, drugs	○	○
29. Blood transfusion prior to 1990 Blood products prior to 1987	○	○
30. HIV positive diagnosis	○	○
31. Received/receiving chronic hemodialysis	○	○
32. Do you have any of the following physical aids?		
a. Eye glasses or contact lenses	○	○
b. Hearing aid	○	○
c. Any braces or back support	○	○
d. Artificial limbs	○	○
e. False teeth	○	○

PART H - HOSPITALIZATION HISTORY - HEALTH SERVICE ONLY-MD/PA/RNP/RN/LPN

(include approximate dates, name of hospital/physician, diagnosis, surgery

resident denies hospitalization this past year

PART I - DENTAL HEALTH HISTORY

Have you ever been told by a doctor or have you ever had:

☐ None Reported

Yes	No	
○	○	Heart murmur, mitral valve prolapse, rheumatic fever, artificial joints
○	○	Diabetes
○	○	Seizures, epilepsy or convulsive disorder
○	○	High or Low blood pressure
○	○	Latex allergy

○	○	Phen-phen use for dieting
○	○	Cold sores/herpes
○	○	Kidney or bladder problems
○	○	Liver condition such as hepatitis, jaundice or cirrhosis
○	○	TB or positive skin test
○	○	Hemophilia/bleeder
○	○	AIDS/HIV +
○	○	Heart attack
○	○	Fainting or dizzy spells
○	○	Arthritis
○	○	Received chemotherapy, x-ray, radium or cobalt treatments
○	○	Cancer or tumor
○	○	Use tobacco products
○	○	Use drugs/narcotics/meth
		Allergic to or bad reaction to any of the following?
○	○	Penicillin
○	○	Other anitbiotics
○	○	Aspirin
○	○	Local anesthetics (numbing for dental work)
○	○	Other medicines

Patient Signature	Joyce Hake
Date Signed	02/02/2016
	Date Signed

Show Last Updated Information

Name: Shipp, Craig A. ADC #: 660878 PID #: 0091262

MSSS031B Monday November 05, 2018 03:37:33 PM

Lab Test Order/Procedure

Ordered Date:	02/01/2016	Time:	12:47:47 PM	Encounter Type:	HIV Intake Testing
Location:	SW AR CCC [SWC]	Staff:	Brown, Nadia		
Verbal By:	Lomax, Lorene STOCKBERGER, Physician				

(◉) Formulary ( ) Non-Formulary

Lab Test Ordered*: Hemoglobin A1c/hemoglobin total in blood [LC-001453]

National HIE Code(s)

LOINC: 30313-1 - Hemoglobin [Mass/Volume] In Arterial Blood;

Priority*: Rout (Draw-10days;Rslts-48hrs)

Fasting*: No

Order Number: 009126200004CS

Instructions

Specimen Collected Date:	02/01/2016	Time:	01:19:00 PM
Staff:	Brown, Nadia		
Specimen Type:	Blood (Venous)	Volume:	Unit:
Control Number:	009126200001		

Specimen Comments

Lab Test Results

Observation Code	Result	Unit	Abnormal Flag	Reference	Result Status	Analyze
L001481	7.3	%	Above High Normal	4.8-5.6	Final Results	

Lab Test Site:	Tested Off-Site	Vendor:	1100
Results Received Date:	02/02/2016	Time:	03:01:01 AM
Test Results:	See Report		

DA

PAGE: 1

Shipp, Craig
ADC#: 660878
SEX: M D/O/B:

Brown, Nadia
COLLECTION DATE: 02/01/2016 13:18

NAME: Shipp, Craig Alan **ADC#:** 660878 **SSN:**
RACE: Caucasian **GENDER:** Male **DATE OF BIRTH:** **AGE:** 47

DATE	ENCOUNTER NOTES
02/05/2016 at: 08:18 AM	**TYPE:** Sick Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Smith, Kindall Nicole **SETTING:** Health Services Office
	S **NOTES:** Deformed feet and toes due to charcot joint. Also diabetes
	O **NOTES:** Upon resident taking his shoes off left sock noted to be covered in blood. Bilateral feet have deformities noted. Left foot has a open area about the size of a silver dollar with skin only attached by the corner. Resident has already had his left great toe removed 4 or 5 years ago from infection that went to the bone. Unit MD here skin was removed by MD. Area was cleaned with wound cleanser, TAO applied, and then covered with 2x2's and roll Kerlix. Resident will return to medical daily in the PM after showers to have dressing changed. Unit MD gave orders for ABT Clindamycin 300 mg QID x 14 days. Unit MD also instructed resident to notify his family of ordering him a pair of shoes to be sent in from the manufactory. Right foot assessed no open areas noted at this time.
	A **NOTES:** Alteration in Comfort
	P **DRUP PRESCRIPTION:** Clindamycin Hcl Cap **DOSAGE:** 2 **STRENGTH:** 150MG **FREQ:** Four Times Daily **FOR:** 14 **DAYS** **ROUTE:** By Mouth **METHOD:** Unit Dose # **REFILLS:** 0 **EXPIRATION DATE:** 02/19/2016 **NOTES:** Return to medical q PM for daily dressing change. Clean area with wound cleanser, apply TAO, and cover with 2x2's and roll kerlix. Clindamycin 300 mg po QID x 14 days STAT start from stock. Temporary elevator pass up and down x 5 days ---VORB--- Naprosyn 220 mg 1 po BID prn x 5 days
	E **NOTES:** Gave the inmate verbal instructions regarding the medical treatment that he is being given. Resident verbalized understanding
	STANDARD FORM(S) Medical Restrictions/Limitatn. **DATE PREPARED:** 02/05/2016
	SCORE: **P:** **U:** **L:** **H:** **E:** **M/H:** 1 **DNTL:** 2 **F:** **B:** **D:** **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/05/2016 at: 06:47 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	I **NOTES:** Resident here for treatment to left foot. Noted large open area to bottom of left foot. Old skin was cut off by MD today. Area has new pink skin showing through. No bleeding at this time but resident brought sock and bandage with him and shows large amount of serousanguinal drainage on it. Area cleaned and rewrapped with 4x4 and kerlex. Tao applied.
	SCORE: **P:** **U:** **L:** **H:** **E:** **M/H:** 1 **DNTL:** 2 **F:** **B:** **D:** **RESTRICTION NOTES:** None

ADC HEALTH SERVICE REQUEST FORM MSF-202 C revised 2013

Name (Last, First, MI):	ADC #:	Date of birth:	Barracks:	Date of Request:
Shipp Craig A	660878		45	2-3-16

Job Assignment:

Description of the problem: Deformed Feet + toes due to charcot joint. Also Diabetes

I consent to be treated for the above problem. I understand that in accordance with the Department of Correction's policy, I will be charged for healthcare services through deductions of applicable co-payment charges from my resident account, and that if I have insufficient funds to cover the charge, the amount of the co-pay will be set up as an outstanding debt.

INMATE'S SIGNATURE: Craig Shipp DATE: 2-3-16

FOR MEDICAL USE ONLY

FACILITY NAME: SWACCC

DATE RECEIVED BY MEDICAL DEPT: 2.5.16

PRIORITY 1 :See within 24 hours- emergent need ☐ PRIORITY 3:See within 72 hours- routine request ☒

PRIORITY 2: See within 48 hours- urgent need ☐ PRIORITY 4: Face-to-face visit not needed; respond to request in writing ☐

DATE TRIAGED: 2.5.16 TRIAGED BY: (NAME) J. Hales (TITLE) LPN

If the EHR is unavailable, enter nursing sick call notes in this area:

Vital Signs: BP Pulse Temp Resp Wt

Protocol Used:

Subjective:

Objective:

Assessment:

Plan:

Education:

Refer to: [ ] Physician [ ] Mid-level [ ] Mental Health [ ] Dental [ ] Other (List):

Medical Staff Name:

Medical Staff Signature: Title: Date/time: Unit:

Inmate Name: Shipp, Craig ADC #: 660878 Date of Birth:

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
02/06/2016 at: 07:23 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	I **NOTES:** No change in condition to left foot wound. Pink skin in center and soft white wet skin surrounding wound. TX done as ordered.
	SCORE: P: U: L: H: E: M/H: 1 DNTL: 2 F: B: D: **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/07/2016 at: 11:32 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Smith, Kindall Nicole **SETTING:** Health Services Office
	I **NOTES:** Area to the bottom of the left foot treated per order. Area continues to have a open area about the size of a silver dollar. Center of open area is red and meaty. The surrounding skin is white and loose. No drainage noted at this time. No s/s of infection. Resident instructed to keep dressing on this area intact and dry. Resident tolerated treatment well.
	SCORE: P: U: L: H: E: M/H: 1 DNTL: 2 F: B: D: **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/08/2016 at: 11:32 AM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Johnston, Amanda M **SETTING:** Health Services Office
	O **TEMPERATURE:** 0.0 F **PULSE:** 75 **RESPIRATION:** 0 **BP:** 118/70 **HEIGHT:** 74 in. **O2 SAT:** 0.00% VIA
	NOTES: None.
	I **NOTES:** Check Blood Pressure.
	SCORE: P: U: L: H: E: M/H: 1 DNTL: 2 F: B: D: **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/08/2016 at: 10:00 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** area to bottom of left foot cleaned with wound cleanser, skin pink in color. wound dressed per protocol
	SCORE: P: U: L: H: E: M/H: 1 DNTL: 2 F: B: D: **RESTRICTION NOTES:** None

AR ADC — MEDICAL PATIENT TREATMENT RECEIVED — PAGE: 6 of 233

EPORT NO. CHSR165 - 14 — PROCESSED: 02/07/2018 09:22 AM

FROM: 02/01/2016 TO: 02/07/2018 REQUESTOR: Lorene Claibourne

NAME: Shipp, Craig Alan ADC#: 660878 SSN:

RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
02/09/2016 at: 08:22 AM	**TYPE:** Physical Exam **LOCATION:** SW AR CCC **STAFF NAME:** Lemdja, Mimo **SETTING:** Health Services Office
	S **NOTES:** Inmate is in here for intake physical Labs today are abnormal for an elevated A1C PMHx: DM-2, HTN, HLD, Obesity, PN, DM foot ulcer PSurgHx: Toes amputation, rt Knee surgery FHx: HTN(father), CAD(Father, and mother's brother), DM(father), CVA(father) father is dead from DM complications Trauma: No GSW, NO stabbing wound, Minor MVA Social Hx: Smoked no cig but dip about a can a day, Etoh used 5 bottles of vodka a day but quit about 6 months ago, Drugs used: Inh methamphetamine but stop about 18 years ago. Single with one child Meds: Metformin, pravastatin, amlodipine, lisinopril, and clindamycin
	O **NOTES:** See physical examination
	A **NOTES:** Intake physical DM-2 HTN HLD DM foot ulcer
	P **LAB TEST ORDERED:** CMP13+LP+2AC+CBC/D/Plt **APPT SCHEDULED FOR:** Lab **ON:** 02/19/2016 **AT:** 08:43 AM **WITH:** **NOTES:** Continue current therapy F/U chronic care
	E **NOTES:** Gave the inmate verbal instructions regarding the medical treatment that he/she is being given.
	STANDARD FORM(S) Lab Test Order **DATE PREPARED:** 02/09/2016 Physical Examination 02/09/2016
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0

DATE	ENCOUNTER NOTES
02/09/2016 at: 10:06 AM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Johnston, Amanda M **SETTING:** Health Services Office
	O **TEMPERATURE:** 0.0 F **PULSE:** 71 **RESPIRATION:** 0 **BP:** 135/94 **HEIGHT:** 74 in. **O2 SAT:** 0.00% VIA
	NOTES: None.
	I **NOTES:** Wrap on the right foot came off therefore this nurse rewrapped the area as directed. Check Blood Pressure.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0

All sections of this form have been fully signed so it can no longer be updated.

ARKANSAS DEPARTMENT OF CORRECTION

Initial Report of Physical Examination MSF-100

Name: Shipp, Craig A. **ADC#:** 660878 **DOB:** _____ **Date:** 02/09/2016 **Time:** 08:22:25

Age	Race	Sex	Height	Weight	Pulse	BP	Drug Allergies/Sensitivities
45	Caucasian	Male					NKDA (No Known Drug Allergies)

Visual Screening **Distant**

	Uncorrected	Corrected
Right		
Left		
Both		

PHYSICAL EXAMINATION	NORM	ABN	N/A	ABNORMAL FINDINGS - DESCRIBE - ENTER ITEM NUMBER
1.Skin	○	●	○	
2.Lymph nodes	○	○	○	17: left foot ulcer with dressing. Wound clean with granulation tissue. Rt foot is deformed
3.Head	○	○	○	
4.Eyes	○	○	○	
5.Ears	○	○	○	Gross Hearing WNL ● Yes ○ No
6.Nose	○	○	○	
7.Throat	○	○	○	
8.Mouth	○	○	○	
9.Neck	○	○	○	
10.Chest (including breast)	○	○	○	
11.Lungs	○	○	○	
12.Heart	○	○	○	
13.Peripheral vessels	○	○	○	
14.Abdomen	○	○	○	
15.Back	○	○	○	
16.Genitals	○	○	○	
17.Extremities	○	○	○	
18.Reflexes	○	○	○	
19.Cranial nerves	○	○	○	
20.Motor examination	○	○	○	
21.Cerebellar examination	○	○	○	
22.Sensory examination	○	○	○	
23.Rectal examination	○	○	●	If rectal refused, inmate signature:
24.Pelvic examination	○	○	●	

BEHAVIORAL ASSESSMENT / MENTAL STATUS	YES	NO	N/A
25.Appearance	○	○	○
26.Behavior	○	○	○
27.Speech	○	○	○
28.Mood/affect	○	○	○
29.Thought content	○	○	○
30.Orientation	○	○	○

31.Memory	○	○	○
32.Attention/Concentration	○	○	○
33.Insight/Judgment	○	○	○

SUPPORTIVE EXAMINATION DATA

	YES	NO	N/A
PPD:	○	○	○
Past Medical Record Requested:	○	○	○
VDRL Drawn:	○	○	○
Sickle Cell Drawn:	○	○	○
HIV Drawn:	○	○	○
Urinalysis Drawn:	○	○	○

PHYSICAL ASSESSMENT PROFILE

P		U		L		H		E	
1	1	1	1	1	1	1	1	1	1

M- 1

ABNORMAL FINDINGS - DESCRIBE - ENTER ITEM NUMBER (CONTINUED)

RESTRICTIONS TO BE TRANSCRIBED TO THE MSF-103

Restrict from assignment requiring prolonged crawling, stooping, running, jumping, walking, or standing, in excess of hours per day. Allow 10 minute break after each hour. ☐	Restrict from assignment requiring strenuous physical activity in excess of hours per day. Allow 10 minute break after each hour. ☐	Restrict from assignment requiring lifting of heavy materials in excess of lbs; and/or overhead work in excess of hours per day. Allow 10 minute break after each hour. ☐
Restrict from assignment requiring continued exposure to loud noises. ☐	Restrict from assignment where sudden loss of consciousness would be dangerous to the inmate or others such as working on scaffolding, driving a vehicle, or working near moving machinery. ☐	Restrict from assignment requiring exposure to high environmental temperature (defined as heat index above 95° without a forced air system) in excess of hours per day. ☐
Restrict from job assignment requiring walking or working on inclines greater than 20 degrees such as ditches or hills. ☐	Restrict from assignment to upper tier of housing unit. ☐	Other limitations: ☐

BRIEFLY COMMENT ON RESTRICTIONS DENOTED ON PULHEX:

Mimo R Lemdja

02/09/2016

Date

Show Last Updated Information

NAME: Shipp, Craig Alan **ADC#:** 660878 **SSN:**
RACE: Caucasian **GENDER:** Male **DATE OF BIRTH:** **AGE:** 47

DATE	ENCOUNTER NOTES
02/09/2016 at: 07:42 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Storey, Tonnya **SETTING:** Health Services Office
	I **NOTES:** Treatment per protocol, Resident tolerated well. Open area pink without drainage noted. No S/S of infection noted
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0

DATE	ENCOUNTER NOTES
02/10/2016 at: 01:34 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Brown, Nadia **SETTING:** Health Services Office
	O **TEMPERATURE:** 0.0 F **PULSE:** 87 **RESPIRATION:** 16 **BP:** 118/78 **HEIGHT:** 74 in. **O2 SAT:** 0.00% VIA
	NOTES: None.
	I **NOTES:** Check Blood Pressure.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0

DATE	ENCOUNTER NOTES
02/10/2016 at: 07:09 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** resident to medical for wound care to bottom left foot. wound care/dressing done per protocol. area to foot pink, dry. resident states there was a lot of drainage on his sock today and agreed to bring sock for wound care 2/11/16.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0

DATE	ENCOUNTER NOTES
02/11/2016 at: 07:21 AM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Smith, Kindall Nicole **SETTING:** Health Services Office
	S **NOTES:** BP checks completed x 7 days ready for review by unit MD
	O **NOTES:** None
	A **NOTES:** None
	P **NOTES:** None
	E **NOTES:** None
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0
	RESTRICTION NOTES: None
	REVIEW NOTES: Most are at goal. OK to stop scheduled BP checks

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
02/11/2016 at: 09:09 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** resident to medical for wound care to bottom left foot. wound tissue pink with thick pale tissue surrounding wound. resident also brought sock he had worn this date to show medical the large amount of pale pink drainage on sock. wound care done per protocol, resident tolerated well. **SCORE:** P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/12/2016 at: 06:27 PM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Brown, Nadia **SETTING:** Health Services Office
	S **NOTES:** Renewing elevator pass until seen by MD on Monday. **O** **NOTES:** None. **A** **NOTES:** None. **P** **NOTES:** None. **E** **NOTES:** None. **STANDARD FORM(S)** Medical Restrictions/Limitatn. **DATE PREPARED:** 02/12/2016 **SCORE:** P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/12/2016 at: 08:56 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** treatment to bottom left foot per protocol. open area pink, surrounding tissue pale in color. resident again brought his sock from today and the sock had a moderate amount of blood tinged drainage. left ankle also with trace edema. resident agreed to elevate foot tonight as much as possible. **SCORE:** P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/13/2016 at: 06:42 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Elmore, Wendy **SETTING:** Health Services Office
	I **NOTES:** Treatment to left foot completed at this time per orders. No drsg on foot when resident was seen d/t resident taking a shower. No drainage noted at this time. **SCORE:** P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None **REVIEW NOTES:** Treatment to left foot completed at this time.

NAME: Shipp, Craig Alan **ADC#:** 660878 **SSN:**
RACE: Caucasian **GENDER:** Male **DATE OF BIRTH:** **AGE:** 47

DATE	ENCOUNTER NOTES
02/14/2016 at: 06:37 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	I **NOTES:** Treatment to left foot continues, noted outer edge of wound with thick soft white skin approx. 15mm surrounding. Inner wound red with small pieces of shaved like skin. No bleeding when cleaned but noted large amount of drainage on old bandage. Resident show this nurse a new blister on right bottom foot. Area measures 1.5 inches x 2 inches. Soft and blood filled. No drainage at this time. Protective dressing placed in case of drainage. Will refer to MD d/t diabetic HX.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0
	RESTRICTION NOTES: None

DATE	ENCOUNTER NOTES
02/15/2016 at: 07:04 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** wound are performed to bottom left foot per protocol. wound open, wound bed pink, tissue surrounding wound pale in color, thick.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0
	RESTRICTION NOTES: None

Name: Shipp, Craig A. ADC #: 660878 PID #: 0091262

CHSS027J

Condensed Health Services Encounter

Wednesday March 07, 2018 02:31:18 PM

ADC #: 660878 Inmate Name: Shipp, Craig A.
ENCOUNTER DATE: 02/16/2016 TIME: 09:18:54 AM DURATION: minutes TYPE: Chronic Care Visit (Doctor)
LOCATION: SW AR CCC [SWC] SETTING: Health Services Office

S NOTES:

Patient reports that he was diagnosed with diabetes for 5-6 years. He has had amputation of his left great toe for osteomyelitis, and has a recurrent ulcer. He has a Charcot joint on his right foot, and now has a pressure spot (hemorrhagic, doesn't look infected) on the bottom of his right mid-foot. He reports that he was treated at UAMS and also had a prolonged hospital stay requiring a PICC line and IV vancomycin last year. He has been prescribed custom insoles and shoes to off-load his foot deformities and try to prevent recurrent ulcers.

He reports that since he has not had his shoes and insoles (about three weeks), he has developed blisters over the pressure points on his feet - the left foot just proximal to the amputation site of his great toe and his right plantar mid-foot.

He reports that he used to drink, but has not been drinking for at least several months. He denies risk factors for HCV.

O PREV: 07:25:33 AM TEMP: 97.3 PULSE: 80 RP: 16 BP: 120/68 HT: 6 ft. 2 in. WT: 228 lb BLOOD SUGAR: NA
NOTES:

Vitals as above.
Good blood pressure control; glycemic control is more variable, per recent eOMIS readings.
HEENT unremarkable. Lungs are clear. Heart is regular without murmurs.
Feet: Bloody sock covering left foot. Left great toe has been amputated, and on the plantar surface of his left toe just proximal to the amputation site, there is a ruptured very large blister, (apparently, per patient, opened by Dr. Lemdja last week) draining serosanguinous exudate, enough to saturate his sock. His right foot and ankle are grossly deformed, with Charcot deformity of his foot and bony pressure point on the plantar mid-foot with overlying hemorrhagic blister, not ruptured at this point - deep to skin surface.

Recent labs:
2/1/2016: Hemoglobin A1c 7.3%
Labs from 2/10/2016:
Glucose 171 mg/dL
K 4.7 mmol/L
CO2 21 mmol/L ***
Creatinine 1.36 mg/dL ***
ALT 45 IU/L ***
Hemoglobin 11.2 g/dL, with RDW 13.5% and MCV 98 fL
Platelets 186 K/cmm
WBC 6.1 K/cmm

Triglycerides 341 mg/dL
HDL cholesterol 32 mg/dL

A RELATED PROBLEM: Chronic Condition - Diabetes
Chronic Condition - High or Low Blood Pressure
Chronic Condition - Diabetic Neuropathy
Chronic Condition - Kidney or Bladder Problems
Medical - Blood and Blood-forming Organs

NOTES:

1. Diabetes, with severe peripheral neuropathy, right foot Charcot deformity, left foot S/P great toe amputation, now with pressure blisters on both feet
2. HTN, good control.
3. CKD, stage II (creatinine 1.36 mg/dL)
4. Anemia, no history of ulcers or blood loss
5. Dyslipidemia

STANDARD FORM: Lab Test Order
STANDARD FORM: Lab Test Order
STANDARD FORM: Lab Test Order
STANDARD FORM: Medical Restrictions/Limitatn.

P DRUG PRESCRIPTION: Chlorhexidine Gluconat Topical Liq/4%
DISPENSE QTY: 1 ORDER #: 1937564 RX #: 68396803
EFFECTIVE DT: 02/16/2016 RT: TP DOSE: 1 STRENGTH: 4% METHOD: Unit Dose
FREQ: QDPRN FOR: 30 DAYS EXPIRATION DATE: 06/08/2016 DELIVERY TM
FRAME: Routine REFILLS: 3
KEEP ON PERSON: No STATUS: Received from Pharmacy
DRUG COMMENTS: Patient with recurrent diabetic foot ulcer (has had great toe amputation, has Charcot joint, past osteomyelitis, etc). Would like chlorhexidine foot soak at HS for him.

DRUG PRESCRIPTION: Sulfamethoxazole-Tmp Ds Tab/800-160
DISPENSE QTY: 20 ORDER #: 1937493 RX #: 68388639
EFFECTIVE DT: 02/16/2016 RT: PO DOSE: 1 STRENGTH: 800-160 METHOD: Unit Dose
FREQ: BID FOR: 10 DAYS EXPIRATION DATE: 02/29/2016 DELIVERY TM
FRAME: Routine REFILLS: 0
KEEP ON PERSON: No STATUS: Received from Pharmacy
DRUG COMMENTS: NKDA

DRUG PRESCRIPTION: Glipizide Tab/5MG
DISPENSE QTY: 30 ORDER #: 1937489 RX #: 68388820
EFFECTIVE DT: 02/16/2016 RT: PO DOSE: 1 STRENGTH: 5MG METHOD: Unit Dose
FREQ: QAM FOR: 30 DAYS EXPIRATION DATE: 08/14/2016 DELIVERY TM
FRAME: Routine REFILLS: 5
KEEP ON PERSON: Yes STATUS: Received from Pharmacy
DRUG COMMENTS: NKDA

DRUG PRESCRIPTION: Ciprofloxacin Hcl Tab/500MG
DISPENSE QTY: 20 ORDER #: 1937499 RX #: 68388785
EFFECTIVE DT: 02/16/2016 RT: PO DOSE: 1 STRENGTH: 500MG METHOD: Unit Dose
FREQ: BID FOR: 10 DAYS EXPIRATION DATE: 02/29/2016 DELIVERY TM
FRAME: Routine REFILLS: 0
KEEP ON PERSON: No STATUS: Received from Pharmacy
DRUG COMMENTS: NKDA

LAB TEST ORDERED: Vitamin B12 and Folate

LAB TEST ORDERED: Hemoglobin A1c/hemoglobin total in blood

LAB TEST ORDERED: Ferritin, Serum

LAB TEST ORDERED: HCV Antibody

LAB TEST ORDERED: Microalbumin, Random Urine

LAB TEST ORDERED: CMP13+LP+2AC+CBC/D/Plt

APPT SCHEDULED: Lab WITH: TBD
ON: 02/26/2016 AT: 09:37:03 AM
APPT SCHEDULED: Lab WITH: TBD
ON: 02/26/2016 AT: 09:37:53 AM
APPT SCHEDULED: Lab WITH: TBD
ON: 02/26/2016 AT: 09:38:21 AM
APPT SCHEDULED: Lab WITH: TBD
ON: 02/26/2016 AT: 09:38:42 AM
APPT SCHEDULED: Lab WITH: TBD
ON: 05/16/2016 AT: 09:39:04 AM
APPT SCHEDULED: Lab WITH: TBD
ON: 05/16/2016 AT: 09:39:29 AM

WAIVERS / RESTRICTIONS (MEDICAL):	Avoid Prolonged Crawling, etc	UNTIL: 02/14/2017
	Restrict from assignment requiring prolonged crawling, stooping, running, jumping, walking, or standing, in excess of 0 hours per day. Allow 10 minute break after each hour.	
SPECIAL EQUIPMENT:	Prescribed Footwear	UNTIL: 02/14/2017
	Prescribed Footwear: needs his own CUSTOM shoes for foot deformity	
SPECIAL EQUIPMENT:	Othopedic Appliance	UNTIL: 02/14/2017
	Orthopedic Appliance: (describe briefly) needs own CUSTOM insoles	
SPECIAL EQUIPMENT:	Other Special Authorizations	UNTIL: 02/14/2017
	Other: Elevator UP & DOWN	

NOTES:

1. It is ABSOLUTELY CRITICAL for him to off-load the pressure point on his feet. He has abnormal weight bearing due to acquired foot deformities and abnormal sensation due to neuropathy, which prevents self protection. This is limb threatening for him. If we cannot accommodate his need for his custom shoes and inserts, he will need to be transferred somewhere where that can happen - if he gets a severe infection again, he is at high risk for amputation. Will order chlorhexidine for foot soaks while he has an open wound and ordered cipro and Bactrim for polymicrobial coverage (including Staph).
2. Added glipizide for better glycemic control.
3. Ordered HCV antibody, urine microalbumin, ferritin and B12 to follow up on his abnormal labs.
4. Follow up with Hgb A1c and CMP in 3 months, with preclinic labs as ordered above (order in 90 days)

E NOTES: Patient educated about treatment plan.

H/S:P: 1 U: 1 L: 1 H: 1 E: 1 D: 2 M: 1

STAFF: Lomax, Lorene STOCKBERGER, Physician

ADC HEALTH SERVICE REQUEST FORM MSF-202 C Revised

Name (Last, First, Middle)	ADC #:	Date of Birth:	Barracks:	Date of Request:
Shipp Craig A	660878		4-5	2-20-16

Job Assignment:

Description of the problem:

Diabetic Ulcer on right foot opened up

I consent to be treated for the above problem. I understand that in accordance with the Department of Corrections policy, I will be charged for healthcare services through deductions of applicable co-payment charges from my resident account, and that if I have insufficient funds to cover the charge, the amount of the co-pay will be set up as an outstanding debt.

INMATE'S SIGNATURE: DATE:

****

FOR MEDICAL USE ONLY

FACILITY NAME: Subec

DATE RECEIVED BY MEDICAL DEPT: 2-21-16

PRIORITY 1 : See within 24 hours- emergent need ☐ PRIORITY 3: See within 72 hours- routine request ☐

PRIORITY 2: See within 48 hours- urgent need ☒ PRIORITY 4: Face-to-face visit not needed; respond to request in writing ☐

DATE TRIAGED: 2-21-16 TRIAGED BY: (NAME) MStone LPN (TITLE) LPN

If the EHR is unavailable, enter nursing sick call notes in this area:

Vital Signs: BP Pulse Temp Resp Wt

Protocol Used:

Subjective:

Objective:

Assessment:

Plan:

Education:

Refer to: [ ] Physician [ ] Mid-level [ ] Mental Health [ ] Dental [ ] Other (List):

Medical Staff Name:

Medical Staff Signature Title: Date/time: Unit:

Inmate Name: Shipp, Craig ADC # 660878 Date of Birth

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
02/21/2016 at: 12:25 PM	**TYPE:** Sick Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** res here for sick call stating that the blister on the bottom of right foot had busted. res is requesting to be put back on the list to see the MD
	O **TEMPERATURE:** 0.0 F **PULSE:** 0 **RESPIRATION:** 0 **BP:** 0/0 **HEIGHT:** 74 in. **O2 SAT:** 0.00% VIA
	NOTES: None.
	A **NOTES:** None.
	P **NOTES:** none
	E **NOTES:** none
	STANDARD FORM(S) Refusal of Treatment **DATE PREPARED:** 02/21/2016
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/21/2016 at: 06:55 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	I **NOTES:** Resident here for 20 min foot soak. Tol. well. Areas on both feet remain unchanged at this time. Will continue to monitor.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
02/22/2016 at: 09:12 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** resident soaked left foot x 20 minutes per protocol. aa large amount of bloody drainage noted on sock. wound bed pink in color with surrounding tissue pale and thick.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0 **RESTRICTION NOTES:** None

ADC HEALTH SERVICE REQUEST FORM MSF-202 C revised 2013

Name (Last, First, MI):	ADC #:	Date of birth:	Barracks:	Date of Request:
Shipp	660878		5th	3-9-16

Job Assignment: N/A

Description of the problem: open diabetic ulcers

I consent to be treated for the above problem. I understand that in accordance with the Department of Correction's policy, I will be charged for healthcare services through deductions of applicable co-payment charges from my resident account, and that if I have insufficient funds to cover the charge, the amount of the co-pay will be set up as an outstanding debt.

INMATE'S SIGNATURE: Craig Shipp DATE: 3-9-16

FOR MEDICAL USE ONLY

FACILITY NAME: SWACCC

DATE RECEIVED BY MEDICAL DEPT: 3.10.16

PRIORITY 1 :See within 24 hours- emergent need ☐ PRIORITY 3:See within 72 hours- routine request ☐

PRIORITY 2: See within 48 hours- urgent need ☒ PRIORITY 4: Face-to-face visit not needed; respond to request in writing ☐

DATE TRIAGED: 3.10.16 TRIAGED BY: (NAME) J. Hukes (TITLE) L

If the EHR is unavailable, enter nursing sick call notes in this area:

Vital Signs: BP Pulse Temp Resp Wt

Protocol Used:

Subjective:

Objective:

Assessment:

Plan:

Education:

Refer to: [ ] Physician [ ] Mid-level [ ] Mental Health [ ] Dental [ ] Other (List):

Medical Staff Name:

Medical Staff Signature: Title: Date/time: Unit:

Inmate Name: Shipp, Craig ADC #: 660878 Date of Birth

NAME: Shipp, Craig Alan **ADC#:** 660878 **SSN:**
RACE: Caucasian **GENDER:** Male **DATE OF BIRTH:** **AGE:** 47

DATE	ENCOUNTER NOTES
02/24/2016 at: 03:58 AM	**TYPE:** Medication Renewal (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Hake, Joyce **SETTING:** Health Services Office
	S **NOTES:** This encounter was system generated for a prescription drug order.
	O **NOTES:** None.
	A **NOTES:** None.
	P **DRUP PRESCRIPTION:** Amlodipine Besylate Tab **DOSAGE:** 1 **STRENGTH:** 10MG **FREQ:** Every Morning **FOR:** 30 **DAYS** **ROUTE:** By Mouth **METHOD:** Daily Dose # **REFILLS:** 5 **EXPIRATION DATE:** 07/12/2016 **NOTES:** None.
	E **NOTES:** None.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0

DATE	ENCOUNTER NOTES
02/24/2016 at: 09:01 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** resident soaked left foot x 20 minutes per protocol. on arrival, sock soaked in bright red blood, and nurse had to elevate foot and hold pressure to wound to stop blood. looking at the wound, at approximately 8 o'clock, 2 small areas appeared open and was bleeding. wound dressed, dressing was re-enforced and resident returned to floor in wheel chair after being advised to keep foot up as much as possible.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/10/2016 at: 10:41 AM	**TYPE:** Follow-up Care (Doctor) **LOCATION:** SW AR CCC **STAFF NAME:** Lomax, Lorene STOCKBERGER **SETTING:** Health Services Office
	S **NOTES:** Patient was seen by Dr. DeHaan, Orthopedic surgeon at Collom & Carney clinic yesterday. He had a cast put on his right lower leg and foot. He reports that shortly after his return, he noticed that the side of the cast was cutting into his right little toe and macerating the top of it. He also says it feels too tight around his ankle. Originally, we had requested a referral to a podiatrist who had been recommended by the wound clinic at Wadley Hospital. However, that podiatrist was on vacation, so the podiatrist's office referred him to Dr. DeHaan so that he could be seen in a more timely fashion.
	O **NOTES:** Vitals as above. Patient is walking with two "post-op" type Velcro strapped shoes and a thick soft dressing on his left foot and a fiberglass knee high cast on the right. His toes on the right are not edematous and they are warm. The dorsal surface of his right 5th toe is macerated and bloody, without obvious signs of infection.
	A **RELATED PROBLEM:** Chronic Condition - Diabetic Neuropathy **NOTES:** Diabetic foot ulcers, with cast applied yesterday that is causing pressure and maceration on his right 5th toe.
	P **APPT SCHEDULED FOR:** Follow-up Care (Doctor) **ON:** 03/14/2016 **AT:** 09:35 AM **WITH:** Doctor/Midlevel, Medical **ACTION:** **CATEGORY:** Waivers / Restrictions (Medical) **TYPE:** No Duty **ACTION:** **CATEGORY:** Waivers / Restrictions (Medical) **TYPE:** No Sports Activities **ACTION:** **CATEGORY:** Waivers / Restrictions (Medical) **TYPE:** No Yard Call **BEGIN DATE:** 03/10/2016 **END DATE:** 04/09/2016 **NOTES:** Entered urgent consultation request for patient to go back to Dr. DeHaan's office to get his cast revised so it doesn't cause another ulcer on his right 5th toe. Wheelchair for now to off-load his foot completely. Entered routine consultation request for patient to follow up with podiatry, as originally planned. Daily protective dressings to right 5th toe.
	E **NOTES:** Patient educated about care plan
	STANDARD FORM(S) Medical Restrictions/Limitatn. **DATE PREPARED:** 03/10/2016
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0
	RESTRICTION NOTES: None
	REVIEW NOTES: Treatment sheet completed for daily dsg changes to both feet and placed in treatment book. Highlighted that treatment nurse will need to pay close attention to 5th toe on Rt. foot. Copy of MD progress note given to Asst. HSA regarding consults suggested.

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/11/2016 at: 11:34 AM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** At approx. 1030 I was going down stairs to pass medication in seg. When I got to the elevator this res was standing there waiting to get on the elevator without the wheelchair that was given to him so he could stay off his feet. I asked res where it was he said oh I can't use that is makes my left shoulder sore.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/11/2016 at: 12:12 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** Treatment Call Encounter generated by Pending Treatment Order screen.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/11/2016 at: 01:44 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** Treatment Call Encounter generated by Pending Treatment Order screen.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/11/2016 at: 09:40 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I **NOTES:** resident walked into medical and stated he already been up for dressing earlier this day.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/12/2016 at: 06:03 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Storey, Tonnya **SETTING:** Health Services Office
	I **NOTES:** Resident came to medical for treatment to the right toe. Resident walked up here and when asked where his wheelchair was Resident stated "It is making my left shoulder hurt to bad to use it. I only want to hurt in one place so I figured my foot was a good place to hurt. I am not going to use that wheelchair." Treatment done per protocol. Resident encouraged to use wheelchair per Dr. Lomax's orders.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/13/2016 at: 05:02 AM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	S **NOTES:** Resident came to pill window without his wheelchair. When asked why he stated that it hurts his shoulder, Nurse stated that the wheel chair was more important d/t the condition of his right foot and he stated he wasn't going to use his w/c.
	O **NOTES:** None
	A **NOTES:** None
	P **NOTES:** None
	E **NOTES:** None
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None **REVIEW NOTES:** noted

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/14/2016 at: 05:04 AM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Stoner, Melissa J **SETTING:** Health Services Office
	S **NOTES:** Resident here at pill window again with out his W/C. Resident states that it makes his shoulder hurt and he cannot tolerate pain in his shoulder and in his foot. I asked resident why had told this nurse he had "no feeling at all in his feet" and he replied "I don't have any feeling in my feet". Nurse then explained to resident that if he could not feel the cast on his foot, it would be in his best interest to use the wheelchair to prevent anymore damage/injury to his foot. Resident stated "you have a point", but still amb with out wheelchair.
	O **NOTES:** None
	A **NOTES:** None
	P **NOTES:** None
	E **NOTES:** None
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0
	RESTRICTION NOTES: None
	REVIEW NOTES: noted

DATE	ENCOUNTER NOTES
03/14/2016 at: 09:23 AM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** Treatment Call Encounter generated by Pending Treatment Order screen.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0
	RESTRICTION NOTES: None
	ADDENDUM: 03/14/2016 09:45:06 Frye, Jane A res came to medical with another resident pushing him in his wheelchair. res advised that he is to wheel himself, res stated okay. res taken to tx room to do tx on bilat feet as ordered. res has a cast on the right foot that is cutting into his pinky toe. cast is bloody, toe has a deep laceration from where the cast is rubbing it as well as the next toe now. area cleaned with wound cleanser and Vaseline gauze applied as ordered as well as stuffing around cast to prevent any further damage of toe. toes are moist in between the and it is causing skin to slough off and have drainage. Left foot has an area behind where great toe should be but has been amputated. area has a great thickness that is surrounding an open area. the open area is not bleeding and is pink in color. thickness is splitting and is going into open area of foot. area cleaned and Vaseline gauze drsg applied and covered.

Collom & Carney Clinic

Collom & Carney Clinic Association 5002 Cowhorn Creek Road, Texarkana, TX 75503

PATIENT: CRAIG SHIPP
DOB:
HISTORIAN: self
VISIT TYPE: Office Visit Established patient
PROVIDER: Jeffrey T. DeHaan MD
DATE OF SERVICE: 03/14/2016
PERSON #: 416674
SEX: male
AGE: 45 year old

This 45 year old male presents for RT FOOT WOUND.

History of Present Illness:

1. RT FOOT WOUND

Craig is here today as a work in having problems with his right foot. The edge of the cast rubbing on his fifth toe he was well-padded. He does have a second-degree skin loss at the base of the second toe. We will going to go ahead and put a sterile dressing on it. He has an appointment to see the wound center on Wednesday. Interestingly the plantar ulcer that he had has improved just in the 5 days he had the cast on.

Past Medical History (Detailed)

Disease	Onset Date	Comments
Diabetes type 1		
Hypertension		
right knee sx		
hammer toe sx		
2nd and 3rd finger sx		
left great toe amputoted		

Medications (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date	Refilled	Elsewhere
metformin 500 mg tablet	take 1 tablet by oral route 2 times every day with morning and evening meals	03/08/2016			N
lisinopril 2.5 mg tablet	take 1 tablet by oral route every day	03/08/2016			N
amlodipine 2.5 mg tablet	take 1 tablet by oral route every day	03/08/2016			N

Mar 16 2016 02:26PM CollomCarney 9036143517 page 5

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/14/2016 at: 12:50 PM	**TYPE:** Outcount Return **LOCATION:** SW AR CCC **STAFF NAME:** Frye, Jane Ann **SETTING:** Health Services Office
	S **NOTES:** res returned from off site visit to Collom and Carney cast has been removed ace bandage in its place with drsg underneath will get orders and do tx as advised.
	O **TEMPERATURE:** 98.2 F **PULSE:** 87 **RESPIRATION:** 16 **BP:** 109/69 **HEIGHT:** 74 in. **WEIGHT:** 234 lb. **O2 SAT:** 0.00% VIA
	NOTES: right foot with a yellow drsg noted around last two toes on right foot, soft padding to off load bottom of foot- soft curlex drsg-outside with an ace bandage.
	A **NOTES:** alt in skin integrity
	P **NOTES:** cont current tx orders, due to no new tx orders Collom and Carney was contacted and spoke with Moria who is to fax orders/ suggestions ASAP
	E **NOTES:** explained to res that he would need to stay in the wheelchair till he was told to walk again for fear of further damage to feet.
	SCORE: **P:** 1 **U:** 1 **L:** 1 **H:** 1 **E:** 1 **M/H:** 1 **DNTL:** 2 **F:** 0 **B:** 0 **D:** 0 **RESTRICTION NOTES:** None
	REVIEW NOTES: noted

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/16/2016 at: 12:08 PM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Smith, Kindall Nicole **SETTING:** Health Services Office
	S **NOTES:** Resident in medical inquiring about when his treatment time was. Instructed resident that his treatment is in the PM after his showers. Resident stated that he didn't know cause it was down on day shift yesterday. Instructed resident that it was due to his bandage being off. At this time resident's bandage is intact and secure on bilateral feet. Resident walking in medical without a wheelchair at this time.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/16/2016 at: 03:57 PM	**TYPE:** Outcount Return **LOCATION:** SW AR CCC **STAFF NAME:** Brown, Nadia **SETTING:** Health Services Office
	S **NOTES:** Resident returned from Wound Care Clinic, Dr. William Tompkins at Christus St. Michael. Resident has paper work from appointment for return visit and wound care, and also to check blood sugar daily. Resident is to wear diabetic shoes with inserts and remain off feet as much as possible. Resident will be seen by MD on 3/17/16 to review paper work.
	O **TEMPERATURE:** 98.0 F **PULSE:** 87 **RESPIRATION:** 16 **BP:** 132/83 **HEIGHT:** 74 in. **WEIGHT:** 235 lb. **O2 SAT:** 0.00% VIA
	NOTES: No acute distress noted, resident laughing and talking with this nurse about how the doctor was acting over a the wound clinic. Denies any pain or discomfort at this time.
	A **NOTES:** Resident bilateral feet wrapped in Gauze bandages at this time, resident states they did not have anything to cover theme with so I just I will just use trash bags when I shower.
	P **NOTES:** Resident informed to return to medical before he showers and the nurse will tape trash bags around his feet. Paper work placed in doctors book to be reviewed on 3/17/16. Treatment sheet made for daily treatment, accu check sheet made also.
	E **NOTES:** None
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None
	REVIEW NOTES: patient seen by me in clinic today

NAME: Shipp, Craig Alan **ADC#:** 660878 **SSN:**
RACE: Caucasian **GENDER:** Male **DATE OF BIRTH:** **AGE:** 47

DATE	ENCOUNTER NOTES
03/16/2016 at: 06:59 PM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	S **NOTES:** resident walked into medical and was asking questions pertaining to how to protect feet while bathing or showering. No wheelchair was visible at this time.
	O **NOTES:** None.
	A **NOTES:** None.
	P **NOTES:** None.
	E **NOTES:** None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
03/21/2016 at: 09:39 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I NOTES: wound care performed to bilateral feet. no drainage noted, resident in wheelchair in medical.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/22/2016 at: 12:50 PM	**TYPE:** Record Review (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Steirer, Patty S **SETTING:** Health Services Office
	S NOTES: Resident to commissary to pick up commissary, Katy in Commissary
	O NOTES: Katy from commissary contacted this nurse to report that resident went to pick up his commissary. Ms. Katy reported that resident picked up two bags of commissary, placed them in the w/c and pushed the w/c back up the ramp in front of the commissary window and got on the elevator to go back to his assigned floor. Ms. Katy reports that she will be reporting every time she sees resident out of w/c. Expressed thanks from medical department and encouraged Ms. Katy to please report any non compliance with w/c.
	A NOTES: None.
	P NOTES: None.
	E NOTES: None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

DATE	ENCOUNTER NOTES
03/22/2016 at: 09:00 PM	**TYPE:** Treatment Call (Nurse) **LOCATION:** SW AR CCC **STAFF NAME:** Cunningham, Brenda **SETTING:** Health Services Office
	I NOTES: wound care to bilateral feet. no drainage noted during this time. bilateral feet with trace edema. resident left medical in wheelchair.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0 **RESTRICTION NOTES:** None

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Hospital
4301 West Markham Street
Slot #524
Little Rock AR 72205
Inpatient Record

Shipp, Craig A
MRN: 003128944, DOB: , Sex: M
Adm: 5/11/2016, D/C: 5/17/2016

Discharge Summaries - Encounter Notes (continued)

Discharge Summaries by Chelsea S Mathews, MD at 5/17/2016 5:34 AM (continued) Version 1 of 2

Admission Diagnoses: Bilateral diabetic foot ulcer associated with secondary diabetes mellitus [E08.621, L97.529, L97.519]

Discharge Diagnoses: same

Admission Condition: fair

Discharged Condition: good

Indication for Admission: bilateral diabetic foot ulcers with right side probing to bone

Hospital Course: Patient was admitted from clinic with severe diabetic foot ulcer to RLE. Plantar ulcer with foul odor and probed to bone. Started on IV abx on admission. Underwent debridement of R foot ulcer on HD#2. Tolerated procedure well and wound vac was placed. LLE casted. ID was consulted who recommended treating as osteo even though MRI did not show osteo. PICC line placed. Patient's pain is well controlled. Concern for gouty flare-up R knee. Otherwise no complaints and ready for discharge.

Recommendations from ID as follows:
PO Levofloxacin 500mg Q24h and PO Metronidazole 500mg TID when he is otherwise ready for discharge (can continue Pip/Tazo for now)
--continue IV Vancomycin, goal trough 15-20, dosed 1250mg Q12H as inpatient
--will need weekly Vancomycin troughs and BUN/Creatinine while on therapy
--Stop date is June 24, 2016
--Please fax lab results to 501-603-1480 or call results to 501-603-1616 opt #3

Consults: ID

Significant Diagnostic Studies: labs: cbc, bmp and microbiology: wound culture: NGTD

Treatments: IV hydration, antibiotics: vancomycin and Zosyn, analgesia: Vicodin and surgery: I&D R foot with wound vac

Discharge Exam:
See daily progress note

Disposition: Home or Self Care

Patient Instructions:

Current Discharge Medication List

START taking these medications

Details

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
05/18/2016 at: 02:31 PM	TYPE: Hospital Admission (Doctor) LOCATION: Ouachita River Correctional Unit Hospital STAFF NAME: McKinney, Gregory Scott SETTING: Health Services Office
	S NOTES: HPI:45 YO IM from ACC Texarkana that was sent to Ortho Clinic for Diabetic foot Ulcers and was admitted from Clinic after Diabetic foot Ulcer on plantar surface of RLE was probed down to bone and had malodor. he was started on IV ABX and taken to OR on HD#2 for debridement by Dr.Ruth Thomas and wound vac was placed and LLE was casted- ID was consulted and recommended treating it as Osteomylitis eventhough MRI was Negative for Osteo-PICC line was placed and was started on Vanconmycin 1250mg Q 12 and Zosyn but was changed to Levofloxacin 500mg PO QD and Flagyl 500mg PO TID prior to transfer with Stop date of 6-24-16- Check weekly troughs with Goal of between 15-20. He also had was was felt to be a Gouty Flare up of Right Knee with large effusion- He has had previous Arthroscopic Surgery on same Knee. Pain well controlled on Hydrocodone 5/325mg PO QID-he had WV drerssing change last PM prior to arrival at SNU and will next need to be Changed on Friday and then continue M-W-F schedule- I was called by Dr.Mathews at UAMS and given report prior to transfer. PMHX:DM type 2 dx 4 years ago HTN CKD Stage 2 DPN Hammer toes Diabetic Foot Ulcers PSHX: Amputation Left Great Toe Hammer toe repair Arthroscopic Surgery R Knee Debridement Diabetic Ulcer right foot ALLERGIES:NKDA Medications: correct in EOMIS MAR FM HX: Mother-DM Cancer Father- DM,HTN CVA- siblings with CAD and DM Social HX: HS Grad currently Disabled- Single 1 child- tobacco-smokless 1 can/day x 30 years, ETOH-ABUSE Denies ilicit Drugs ROS: 14 point ROS negative accept as stated in HPI
	O NOTES: WDWNWM in NAD A&Ox3 Pleasent and Cooperative- EOMI PERRLA anicteric sclera OC/OP clear MMM Neck supple FROM Lungs CTA B Heart RRRsMGR(84) no ectopy ABD Soft NTND Pos BS no rebound or guarding EXT LLE in Cast, RLE WOUND VAC Dressing in place good seal in Night Splint-Right Knee Swollen Pos effusion no warmth or erythema Flex to 90 full extension TTP Popliteal Fossa no cyst felt -Moving all ext- Neuro CN 2-12 intact
	A NOTES: SP Debridement Plantar Diabetic Foot Ulcer Mid Foot with presumed Osteomylitis with wound VAC DM HTN Gout VS DJD right Knee with hx of old Meniscal tear
	P DRUP PRESCRIPTION: Docusate Sodium Cap DOSAGE: 1 caps STRENGTH: 100MG FREO: Twice Daily FOR: 30 DAYS ROUTE: By Mouth METHOD: Unit Dose # REFILLS: 1 EXPIRATION DATE: 07/17/2016 LAB TEST ORDERED: Vancomycin Trough, Serum CMP13+LP+2AC+CBC/D/Plt APPT SCHEDULED FOR: Lab ON: 05/19/2016 AT: 08:00 AM WITH:

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

Lab ON: 05/19/2016 AT: 08:10 AM WITH:
Hospital Admission (Doctor) ON: 05/24/2016 AT: 12:30 PM WITH: Univ of Ark Med Ctr, Staff

ACTION: CATEGORY: Special Diets (Medical) TYPE: 2600-2800 High Calorie Diet
BEGIN DATE: 05/18/2016 END DATE: 05/17/2017

NOTES:

ADMIT SNU
DX:SP Debridement Plantar Diabetic Foot Ulcer Mid Foot with presumed Osteomylitis with wound VAC
Condition:GOOD
Nursing: Weekly weights/ VS q shift/ FSBS every Monday AM and PRN/ Wound VAC dressing Changes M-W-F/ PICC Line care
LAB: CBC/CMP and Vanc trough every Monday/Thursday
ALLERGIES: NKDA
MEDICATIONS: Correct in EOMIS MAR
DIET: ADA High
Activity: WBAT LLE,NWB RLE up to Toilet/Pillow under right Knee and Ice PRN Keep RLE in Night Brace
Followup UAMS Ortho in 1 week

E NOTES: Gave the inmate verbal instructions regarding the medical treatment that he is being given.

STANDARD FORM(S) Special Diet Request DATE PREPARED: 05/18/2016
Lab Test Order 05/18/2016

SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0

RESTRICTION NOTES: None

REVIEW NOTES: noted

DATE	ENCOUNTER NOTES
05/18/2016 at: 03:26 PM	TYPE: Medication Renewal LOCATION: Ouachita River Correctional Unit Hospital STAFF NAME: McKinney, Gregory Scott SETTING: Health Services Office

S NOTES: This encounter was system generated for a prescription drug order.

O NOTES: None.

A NOTES: None.

P DRUP PRESCRIPTION: Hydrocodone-Acetaminophen Tab
DOSAGE: 1 STRENGTH: 5-325MG
FREQ: Four Times a Day As Needed FOR: 30 DAYS
ROUTE: By Mouth METHOD: Crushed in Water/Watch Swallow
REFILLS: 0 EXPIRATION DATE: 06/18/2016

NOTES: None.

E NOTES: None.

SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: 0

10000011582521
SHIPP,CRAIG A
HAR: 1001759500 MRN: 003128944
Male APPT: 5/31/2016
ORTHOPEDIC CLINIC
RUTH L. THOMAS, MD

Arkansas Department of Correction / Arkansas Department of Community
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Off

Reference #: _____ Date of Service: 5-31-16

Inmate: Craig Shipp Inmate ID: 66610878 DOB: _____

Institution: SNU Institution ID: _____ Phone: 501-337-8024

Provider: D Thomas Provider Type: Orthopedics Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)
Wound VAC right foot, Total Contact Cast left foot
Size of ulcers today Lt - 1CM Rt - 3X4 CM
Spoke with Dr. McKinney

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)
Continue VAC changes Rt foot tiw
We will see next Tuesday (only Option)

Can equivalent medication substitution be used? ☐Yes ☐No Follow-up needed? ☐Yes ☐No

If follow-up needed, explain:
TWK

Consulting Provider Name (please print): Ruth Thomas Consulting Provider Signature: Ruth L Thomas Date: 5-31-16

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☑Implement the following

Implement:
FU 2wks with wound
continue WVAC

CHRISTOPHER SANDERSON 6-1-16

Site Provider Name (please print): Site Provider Signature: Date:

called last night on return 1515

10000011585423
SHIPP,CRAIG A
HAR: 1001769950 MRN: 003128944
Male APPT: 6/7/2016
ORTHOPEDIC CLINIC
RUTH L. THOMAS, MD

Arkansas Department of Correction / Arkansas Department of Community
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Offic

Reference #: _____ Date of Service: 6-7-16

Inmate: Craig Shipp Inmate ID: 146878 DOB: _____

Institution: SNU Institution ID: _____ Phone: 501-337-8024

Provider: Dr Thomas Provider Type: Orthopedics Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)

diabetic ulcers left 8 x 9 mm
Right 40 x 30 c hypergranulation tissue

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)

Continue wound VAC Rt foot
~~RTC 2~~ RTC 1 wk for cast change on left + wound VAC change on right

Can equivalent medication substitution be used? ☐Yes ☐No Follow-up needed? ☐Yes ☐No

If follow-up needed, explain:

1 week. See above

Consulting Provider Name (please print): RUTH THOMAS Consulting Provider Signature: Ruth L Thomas MD Date: 6-7-16

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☑Implement the following

Implement:

F/u in 1 week

Angela Williams 6-7-16 1715

Site Provider Name (please print): Site Provider Signature: Date:

10000011658889
SHIPP,CRAIG A
HAR: 1001792913 MRN: 003128944
Male APPT: 6/14/2016
ORTHOPEDIC CLINIC
RUTH L. THOMAS, MD

Arkansas Department of Correction / Arkansas Department of Community C
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Officer

Reference #: _____ Date of Service: 6-14-16

Inmate: Craig Shipp Inmate ID: 160827 DOB: _____

Institution: SNU Institution ID: _____ Phone: 501-337-8024

Provider: Dr Thomas Provider Type: Orthopedic Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)

(B)ilat. DFU, R > L

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)

(B)ilateral DFU:
(R): lots of drainage, pink flesh, needs VAC
(L): Total contact cast, silver-alginate dressing to post. heel

Can equivalent medication substitution be used? ☐Yes ☒No Follow-up needed? ☐Yes ☐No

If follow-up needed, explain: 1 week

Consulting Provider Name (please print): Robert Martin, MD Consulting Provider Signature: Date: 6/14/16

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☑Implement the following

Implement:

Consult completed for
flu vaccine

Site Provider Name (please print): Site Provider Signature: Date: 6-14-16

1848

Name: Shipp, Craig A. ADC #: 660878 PID #: 0091262

MSSS031B

Lab Test Order/Procedure

Monday November 05, 2018 03:34:21 PM

Ordered Date: 06/16/2016 Time: 02:14:26 PM Encounter Type: Hosp In Patient Rounds (Doctor)

Location: Ouachita River Correctional Unit Hospital [U02] Staff: Vowell, Nannette L, MD

Verbal By:

◉ Formulary ○ Non-Formulary

Lab Test Ordered*: Hemoglobin A1c/hemoglobin total in blood [LC-001453]

National HIE Code(s)

LOINC: 30313-1 - Hemoglobin [Mass/Volume] In Arterial Blood;

Priority*: Rout (Draw-10days;Rslts-48hrs)

Fasting*: No

Order Number: 009126200037CS

Instructions

to labcorp on Friday June 17, 2016

Specimen Collected Date: 06/17/2016 Time: 03:46:00 PM

Staff: White, Tara B, RN

Specimen Type: Blood (Venous) Volume: Unit:

Control Number: 009126200016

Specimen Comments

Lab Test Results

Observation Code	Result	Unit	Abnormal Flag	Reference	Result Status	Analyze
L001481	6.8	%	Above High Normal	4.8-5.6	Final Results	☐

Lab Test Site: Tested Off-Site Vendor: 1100

Results Received Date: 06/18/2016 Time: 09:01:13 AM

Test Results: See Report

DA

PAGE: 1

Shipp, Craig
ADC#: 660878

SEX: M D/O/B:

White, Tara B, RN
COLLECTION DATE: 06/17/2016 15:20
RECEIVED DATE: 06/17/2016 19:34
INITIAL REPORT DATE: 06/18/2016 09:17
ACCESSION NO.: 16938203320

<=== DESCRIPTION ===>	<= RESULT =>	<=OUT OF RANGE=>	<= REF RANGE =>	<= UNITS =>	LAB ID
Hemoglobin A1c					
	Performed at: 01 - LabCorp Dallas 7777 Forest Lane Suite C350, Dallas, TX 752302544 Lab Director: CN Etufugh MD, Phone: 9725986000				
Hemoglobin A1c	6.8	* Above High Normal	4.8-5.6	%	01

Pre-diabetes: 5.7 - 6.4
Diabetes: >6.4
Glycemic control for adults with diabetes: <7.0

SCANNED

Arkansas Department of Correction / Arkansas Department of Community Corrections
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Officer)

Reference #: _____ Date of Service: 6-21-16

Inmate: Craig Shipp Inmate ID: 660878 DOB: _____

Institution: SNU Institution ID: _____ Phone: 501-337-8024

Provider: Dr Thomas Provider Type: Orthopedic Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)
Hypergranulation tissue R foot w/ poor healing.
L foot pin point opening @ ulcer

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)
Cast (L) foot for ulcer
Continue wound vac (R) foot
Labs drawn today - ESR- CRP

Can equivalent medication substitution be used? ☐Yes ☑No Follow-up needed? ☑Yes ☐No

If follow-up needed, explain:
1 wk for wound check
WBAT LLE in cast
NWB RLE

Consulting Provider Name (please print): Chelsea Mathews Consulting Provider Signature: [signature] Date: 6/21/16

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☐Implement the following

Implement:
Consult entered

Site Provider Name (please print): Site Provider Signature: NLV 6/22/16

10000011728270
SHIPP,CRAIG A
HAR: 1001810156 MRN: 003128944
Male APPT: 6/21/2016
ORTHOPEDIC CLINIC
RUTH L. THOMAS, MD

SHIPP,CRAIG A
HAR: 1001827476 MRN: 003128944
Male APPT: 6/29/2016
ORTHOPEDIC CLINIC
RUTH L THOMAS, MD

nsas Department of Correction / Arkansas Department of Community Corrections
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Officer)

Reference #: _____ Date of Service: 6-29-16
Inmate: Craig Shipp Inmate ID: 160878 DOB: _____
Institution: SNU Institution ID: _____ Phone: 501-337-8024
Provider: Dr. Thomas Provider Type: Orthopedics Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)
Rt - 5cx3cm diabetic ulcer Rt foot with hypergranulation tissue
Lt - small very superficial ulcer left foot at toe amputation site

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)
(R) diabetic ulcers
(1) Leave wound VAC off right foot X 1 WK
(2) Acticoat wick in deep area of ulcer
(3) Cover c Acticoat & then dry 4X4 over top
(4) Change dressing q 3days or as needed
(5) F/u 1 WK Orthopaedic Foot & Ankle Clinic

Can equivalent medication substitution be used? ☐Yes ☐No Follow-up needed? ☐Yes ☐No

If follow-up needed, explain:

Consulting Provider Name (please print): Ruth Thomas Consulting Provider Signature: Ruth Thomas MD Date: 6-29-16

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☑Implement the following

Implement:
Consult for F/U - will order dressing supplies

Conservative management

Site Provider Name (please print): Site Provider Signature: Date: 6-29-16 1210

Progress Notes - Progress Notes (continued)

Progress Notes by Debbie K. Bryant, LPN at 7/6/2016 1:05 PM (continued) Version 1 of 1

Author: Debbie K. Bryant, LPN | Service: (none) | Author Type: Licensed Nurse
Filed: 7/6/2016 4:22 PM | Encounter Date: 7/6/2016 | Creation Time: 7/6/2016 1:05 PM
Status: Signed | Editor: Debbie K. Bryant, LPN (Licensed Nurse)

Mr. Shipp came in today for clinic visit however someone forgot to call the prison and reschedule his appointment until next week. Dr. Thomas is out of town and Dr. Martin saw her one week patients yesterday. Dressing was removed old dressing had moderate amount of greenish drainage. He continues to grow hypergranulation tissue there are two areas in the middle of this hypergranulation tissue that measures 11/2 cm. In depth. Pictures were taken of the wound and from a side view it appears he has more of a midfoot collapse which is pushing the tissue out of the wound. He has no redness or warmth around the area and the ulcer measures 3.8 X 5 Cm. basically the same as last week. I have sent a recommendation to the prison that they change his dressings to Dakins solution because of the green drainage. This will be up to the prison physician to write the order if he agrees. Today we placed acticoat over the wound 4X4's as a secondary dressing and wrapped with kerlex. I worry he may need more debridement then can be done in the clinic.

Electronically signed by Debbie K. Bryant, LPN at 7/6/2016 4:22 PM

Attribution Key

Attribution information is not available for this note.

Progress Notes by Ruth A Halpine at 7/7/2016 7:32 AM Version 1 of 1

Author: Ruth A Halpine | Service: (none) | Author Type: Technician
Filed: 7/7/2016 7:33 AM | Encounter Date: 7/6/2016 | Creation Time: 7/7/2016 7:32 AM
Status: Signed | Editor: Ruth A Halpine

July 7, 2016- Nursing Note: **Ortho Tech Note**

Provider: ORTHOPEDICS NURSES

Location of care: OUTPATIENT CENTER
ORTHOPEDIC CLINIC
4301 W Markham St
Little Rock AR 72205-7101
501-686-7000

Treatment Type
Cast:applied and removed
Brace:none
Type of Cast or Splint:fiberglass and short leg
Location of Cast or Splint: left

Removal of Hardware
Removal of: none

Skin Assessment
Skin Integrity at Affected Area:intact

Progress Notes - Progress Notes (continued)

Progress Notes by Ruth L. Thomas, MD at 7/12/2016 7:24 PM (continued) Version 1 of 2

Neck: No obvious masses.
Chest: Respirations are not labored.
Right Lower Extremity:
Skin: Hypergranulated tissue in the ulcer base that remaiins about 3 X 5 cm size.
Continues with midfoot deformity, warmth, nonhealing ulcer.
Wound cleaned and dressed today and Dakin's solution dresings initiaed
Imaging: None today

A. nonehealing right foot ulcer. Left has healed. Right will require continuing dressings changes.

P. F/U one week.

Electronically signed by Ruth L. Thomas, MD at 7/12/2016 7:28 PM
Attribution Key
Attribution information is not available for this note.

Progress Notes by Keely Mozisek at 7/13/2016 8:58 AM Version 1 of 1

Author: Keely Mozisek
Filed: 7/13/2016 8:59 AM
Status: Signed
Service: (none)
Encounter Date: 7/12/2016
Editor: Keely Mozisek (Technician)
Author Type: Technician
Creation Time: 7/13/2016 8:58 AM

Treatment Type
Cast:removed
Brace:none
Type of Cast or Splint:fiberglass, diabetic and short leg
Location of Cast or Splint: left

Removal of Hardware
Removal of: none

Skin Assessment
Skin Integrity at Affected Area:intact

Procedure outcome
without complaint
Handouts were given:No
Patient verbalized understanding:Yes

Electronically signed by Keely Mozisek at 7/13/2016 8:59 AM
Attribution Key
Attribution information is not available for this note.

Arkansas Department of Correction / Arkansas Department of Community Corrections
Specialty Provider Consultation Report
(Complete and return in SEALED envelope with Correctional Officer)

Reference #: _____ Date of Service: 7-19-16

Inmate: Craig Shipp Inmate ID: 160878 DOB: _____

Institution: SNU Institution ID: _____ Phone: 501-337-8024

Provider: Dr Thomas Provider Type: Orthopedics Location: UAMS

See Attached Outpatient Specialty Referral for Health Services Authorized

For security reasons, inmates must NOT be informed of recommended treatment or possible hospitalization. Due to security consideration, all recommended tests and treatments are to be scheduled by the Department of Corrections Medical Department.

Review of Case: (Chief complaint, exam findings etc.)

Chronic Rt foot diabetic ulcer.
Has failed conservative management
Recommend repeat MRI labs to include ESR

Diagnosis and Prescription Suggestions (To be reviewed by Correctional Site Medical Director)

C-reactive protein

5.0 x 4.4 hypergranulated diabetic ulcer Rt foot
Erythema, warmth

Can equivalent medication substitution be used? ☐Yes ☐No Follow-up needed? ☐Yes ☐No

If follow-up needed, explain: MRI w contrast Rt foot if available & BUN, Cr OK. Also need ESR, C-reactive protein
Continue dressing D.C.
Return when MRI & lab values available

Consulting Provider Name (please print): Consulting Provider Signature: Date:

To be completed by correctional site health care provider

Recommendation after review of consultant's report: ☐No further action ☐Implement the following

Implement:
MRI
ESR, C-reactive protein HgBA1c, prealbumin
BUN, Cr.

Ruth L Thomas MD Site Provider Name (please print): Ruth L Thomas Site Provider Signature:

10000011995356
SHIPP,CRAIG A
HAR: 1001655041 MRN: 003126944
Male APPT: 7/19/2016
ORTHOPEDIC CLINIC
RUTH L. THOMAS, MD

unknown whether 7-20-16
LAB proc drawn notified
Flu post mn2 of return
7-15-16

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Hospital
4301 West Markham Street
Slot #524
Little Rock AR 72205
Inpatient Record

Shipp, Craig A
MRN: 003128944, DOB:
Adm: 7/29/2016, D/C: 8/5/2016

Sex: M

Discharge Summaries - Encounter Notes

Discharge Summaries by Devendra D. Patel, MD at 8/5/2016 3:07 PM Version 1 of 1

Author: Devendra D. Patel, MD
Filed: 8/5/2016 3:23 PM
Status: Signed

Service: Med-General Internal Medicine
Date of Service: 8/5/2016 3:07 PM
Editor: Devendra D. Patel, MD (Physician)

Author Type: Physician
Creation Time: 8/5/2016 3:07 PM

Physician Discharge Summary

Patient ID:
Craig A Shipp
003128944
45 y.o.
11/11/1970

Admit date: 7/29/2016

Discharge date and time: 8/5/2016, 16:00

Admitting Physician: Sandia Iskandar, MD

Discharge Physician: Devendra Patel, MD

Admission Diagnoses: Cellulitis of right lower extremity [L03.115]
Chronic osteomyelitis of right foot [M86.671]
Diabetic ulcer of right foot associated with type 2 diabetes mellitus [E11.621, L97.519]
Cellulitis [L03.90]

Discharge Diagnoses: Cellulitis, diabetic foot ulcer and chronic osteomyelitis of right lower extremity, Type 2 Diabetes Mellitus, Diabetic foot ulcer left foot

Admission Condition: fair

Discharged Condition: good

Indication for Admission: Worsening diabetic foot ulcer, Cellulitis

Hospital Course:

Patient is a 45 y.o. male with history of HTN, HLD and DM who presented with foot pain and swelling. Patient has nonhealing diabetic right foot ulcer since February 2016. He was followed closely by orthopedic surgery and had multiple surgical debridement and multiple courses of abx. He woke up in the morning of admission day with worsening foot and shin pain, swelling and erythema extending almost to mid shin area. He was having chills, but no fever. Patient noticed foul smelling yellowish green discharge from his right foot ulcer. Patient denied for N/Vomiting/abdominal pain, chest pain, SOB, dizziness, lightheadedness.

Patient initially treated with IV antibiotics Vancomycin and Zosyn. Wound culture grew MRSA and GAS. Patient underwent debridement by Orthopedic. Zosyn was discontinued. Bone cultures collected in OR did not have significant growths. ID/Ortho ID was consulted. As per ID team, patient will be treated for chronic osteomyelitis

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Adm: 7/29/2016, D/C: 8/5/2016

Discharge Summaries - Encounter Notes (continued)

Discharge Summaries by Devendra D. Patel, MD at 8/5/2016 3:07 PM (continued) Version 1 of 1

with Vancomycin IV till 9/12/2016. Patient has PICC line placed. Vancomycin dose adjusted by pharmacy based on trough levels. **Continue vancomycin 1 g IV Q12hr till end date of 9/12/2016. After completion of antibiotics, remove PICC line.**

Patient was managed with home medications for DM and HTN, and was kept on SQ Heparin for DVT prophylaxis.

Consults: Orthopedic, Infectious Disease, Orthopedic Infectious Disease

Significant Diagnostic Studies: radiology: Xray and MRI

Results from last 7 days

Lab	Units	08/04/16 0242
WBC	K/uL	10.18*
HEMOGLOBIN	g/dL	11.1*
HEMATOCRIT	%	33.2*
PLT	K/µL	220

Results from last 7 days

Lab	Units	08/05/16 0330
SODIUM	mmol/L	136
CHLORIDE	mmol/L	103
CO2	mmol/L	24
BUN	mg/dL	17
CREATININE	mg/dL	1.2
CALCIUM	mg/dL	9.1
GLUCOSE	mg/dL	109

X-ray Foot Right Ap Lateral And Oblique
7/29/2016 EXAM DESCRIPTION: XR FOOT RIGHT AP LATERAL AND OBLIQUE CLINICAL INDICATION: ulcer; HISTORY: Foot ulcer COMPARISON: Comparison with prior foot radiographs from 06/21/2016. TECHNIQUE: AP, lateral oblique views of the right foot are presented. FINDINGS: There is increased soft tissue swelling with marked soft tissue irregularity at plantar aspect, possible soft tissue defect. No foreign bodies are noted however. There is considerable worsening of patchy osteopenia and midfoot but no definite focal destructive lesion and no periosteal reaction identified. Mild degenerative changes of the tarsometatarsal joints. Toes appear unremarkable as is heel.

7/29/2016 IMPRESSION: There is increased soft tissue swelling at plantar aspect probable ulcer, no foreign body. Increased mottled osteopenia in midfoot, although no definite findings, osteomyelitis could not be

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Shipp, Craig A
MRN: 003128944, DOB: Sex: M
Adm: 7/29/2016, D/C: 8/5/2016

Discharge Summaries - Encounter Notes (continued)

Discharge Summaries by Devendra D. Patel, MD at 8/5/2016 3:07 PM (continued) Version 1 of 1

absolutely excluded. Electronically Signed by: Philip Kenney, M.D. on 07/29/2016 at 15:38:15

MRI R foot: 07/30/16
IMPRESSION:
1. NO EVIDENCE OF OSTEOMYELITIS IS SEEN.
2. CHANGES OF NEUROPATHIC JOINT WITH MIDFOOT COLLAPSE IS AGAIN SEEN.
3.8 X 2.1 CM CHRONIC DEVITALIZED TISSUE OVERLYING THE CUBOID BONE ALONG THE LATERAL PLANTAR SURFACE IS SEEN.
3. NO DRAINABLE ABSCESS.

Treatments: antibiotics: vancomycin

Discharge Exam:
Filed Vitals:

	08/05/16 0319	08/05/16 0756	08/05/16 0951	08/05/16 1117
BP:	124/78	130/97		128/89
Pulse:	74	81		80
Temp:	98.2 °F (36.8 °C)	97.8 °F (36.6 °C)		98.1 °F (36.7 °C)
Resp:	17	18	17	18
SpO2:	97%	95%		97%

Gen: Alert, well appearing, in no acute distress, Ox3
Neck: No JVD, no bruit.
CV: RRR, S1 and S2 normal, no murmurs, clicks, gallops or rubs.
Lungs: CTAB , no wheezing or rhonchi
ABD: soft, non tender, no distended, + BS
NEURO: no focal neurologic deficits grossly
Extremities: no edema, R toe wound vac in place

Disposition: Court/Law Enforcement

Patient Instructions:
Current Discharge Medication List

START taking these medications

	Details
vancomycin (VANCOCIN) 1,000 mg injection	1,000 mg by IV Push route every 12 (twelve) hours - End Date: 9/12/16 *Qty:* 76000 mg, *Refills:* 0

CONTINUE these medications which have NOT CHANGED

	Details

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
08/09/2016 at: 03:01 PM	TYPE: Hosp In Patient Rounds (Doctor) LOCATION: Ouachita River Correctional Unit Hospital STAFF NAME: Vowell, Nannette L SETTING: Health Services Office
	S NOTES: was to be paroled today - not all in order - will likely go tomorrow. he just wants out.
	O NOTES: awake and alert wound vac was removed in prep for parole. no increase work of breathing CV RRR
	A NOTES: HTN DM HLD NON Healing Right foot ulcer Since Feb 2016- 7/30/2016 MRI showed midfoot neuropathic joint, plantar ulcer no abscess/osteomyelitis- chronic devitialized tissue overlying the cuboid bone along the lateral plantar surface 7/30/2016 Wound culture ORSA + Strep. Pyrogenes (OR microscopy & cultre collected 8/2/2016 reported insufficient growth, reincubated which grew few staph aureus. No anaerobic growth, No AFB Blood cultures no growth in 24 hours. 7/29/2016 Vanc+ zosyn PICC Line inserted 8/4/2016 Excisional irrigation and debridement of the right foot ulcer to periosterum of cuboid+ wound vac placement on 8/1/2016 FULL CODE
	P NOTES: parole soon. meantime continue current plan.
	E NOTES: None.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D:

Name: Shipp, Craig A.
MSSS032A

Vital Signs

ADC #: 660878 PID #: 0091262
Wednesday February 07, 2018 08:51:54 AM

Vital Signs (1 - 205 of 205)

Date	Time	Temp	Pulse	Resp	Height	Weight	Systolic	Diastolic	Blood Sugar	Body Mass Index	
08/10/2016	06:00 AM			0	6 ft 2 in				109		
08/09/2016	05:28 PM	98.1	79	18	6 ft 2 in		134	76	NA		
08/09/2016	02:40 PM			0	6 ft 2 in				101		
08/09/2016	03:48 AM			0	6 ft 2 in				98		
08/08/2016	05:44 PM			0	6 ft 2 in				108		
08/08/2016	05:41 PM	98.9	79	17	6 ft 2 in		137	80	NA		
08/08/2016	09:20 AM			0	6 ft 2 in				122		
08/08/2016	08:30 AM			0	6 ft 2 in				122		
08/08/2016	03:06 AM	97.3	78	18	6 ft 2 in		112	69	118		
08/07/2016	01:46 PM			0	6 ft 2 in				212		
08/07/2016	08:41 AM	96.5	65	14	6 ft 2 in	218 lb	110	65	NA	27.99	
08/07/2016	02:41 AM	97.3	74	18	6 ft 2 in		112	72	151		
08/06/2016	09:30 AM			0	6 ft 2 in				134		
08/06/2016	02:40 AM	97.9	90	18	6 ft 2 in		132	86	179		
08/05/2016	06:45 PM	99.3	91	18	6 ft 2 in	218 lb	154	98	344	27.99	

NAME: Shipp, Craig Alan ADC#: 660878 SSN:
RACE: Caucasian GENDER: Male DATE OF BIRTH: AGE: 47

DATE	ENCOUNTER NOTES
08/10/2016 at: 09:20 AM	TYPE: Hospital Discharge (Nurse) LOCATION: Ouachita River Correctional Unit Hospital STAFF NAME: White, Tara B SETTING: Health Services Office
	S NOTES: Pt states that he is ready to go home and understands his medication regimen.
	O NOTES: Pt sitting up in bed ready to be paroled out. A&O x3 with respirations even and unlabored. Wound vac to right foot secure and in place, removed per physicians orders and wet to dry dressing applied. Wound vac kept here at ORCU to be sent back to KCI. Pt is to receive treatment from home health after leaving ORCU. Medications sent with pt....pt states he has no questions about medication regimen. Pt also has current scripts signed by the physician to take to the pharmacy upon discharge. Pt left hospital in w/c with ADC staff with all belongings, stable condition with no s/s of acute pain or distress noted.
	A NOTES: None.
	P NOTES: F/u with home health.
	E NOTES: Gave the inmate verbal instructions regarding the medical treatment that he is being given.
	SCORE: P: 1 U: 1 L: 1 H: 1 E: 1 M/H: 1 DNTL: 2 F: 0 B: 0 D: RESTRICTION NOTES: None

Reason for Call (continued)

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Created by

Encounter creation information not available

Encounter Messages

No messages in this encounter

No questionnaires available.

Progress Notes - Progress Notes

Progress Notes by Ruth L. Thomas, MD at 9/7/2016 7:37 PM Version 1 of 1

Author: Ruth L. Thomas, MD | Service: (none) | Author Type: Physician
Filed: 9/7/2016 7:39 PM | Encounter Date: 9/7/2016 | Creation Time: 9/7/2016 7:37 PM
Status: Signed | Editor: Ruth L. Thomas, MD (Physician)

Follow up for recurrent diabetic ulceration:

PE: Well developed individual. Well nourished. Non-acute distress. Oriented to time, place, and person. Behavior and effect appropriate for this visit.

Normocephalic. Pupils equal and responsive to light. Understands normal speech levels.

Breathing is not labored. Upper extremities with evidence of good perfusion.

right Lower Extremity with ulceration located midfoot and laterally. Foot is still warm. Foot is still red. Decreased drainage. Finishes Vancomycin next Wednesday

A. Slowly healing diabetic ulcer. Today measures 50 X 28 mm. Improving with casting. Will repeat today. I participated in application and checking of cast. Boney prominences were appropriately protected and cast appropriately molded.

P. Follow up next week. On arrival to clinic the cast should be removed to allow inspection of the ulcer.

Electronically signed by Ruth L. Thomas, MD at 9/7/2016 7:39 PM

Attribution Key

Attribution information is not available for this note.

Progress Notes by Ruth A Halpine at 9/9/2016 8:22 AM Version 1 of 1

Progress Notes - Progress Notes (continued)

Progress Notes by Ruth L. Thomas, MD at 9/14/2016 6:57 PM (continued) Version 2 of 3

Occupational History

- disabled — Not Employed
- — Disabled

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: No
- Drug Use: No
- Sexual Activity: No

Other Topics	Concern
• Not on file	

Social History Narrative

Family History:

Family History

Problem	Relation	Age of Onset
• Diabetes	Father	
• Stroke	Father	
• Diabetes	Sister	

CC is
Continuing problems with ulceration of the right foot. He has also developed recurrence of the small ulceration on the left foot. He was in a diabetic healing cast on the right on presentation today and wearing a diabetic shoe on the left.

PE:
Vital Signs:
Filed Vitals:

	09/14/16 1410
BP:	123/83
Pulse:	99
Temp:	97.6 °F (36.4 °C)

General: Well developed, well nourished. Non-acute distress.
Pyshyactric: Oriented to time, place and person. Alert. Mood and behavior appropriate for this visit.
Vital Signs:
Filed Vitals:

	09/14/16 1410
BP:	123/83
Pulse:	99
Temp:	97.6 °F (36.4 °C)

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Hospital
4301 West Markham Street
Slot #524
Little Rock AR 72205
Amb Encounter Report

Shipp, Craig A
MRN: 003128944, DOB:
Encounter date: 9/28/2016

Sex: M

Progress Notes (continued)

Ruth L. Thomas, MD at 9/28/2016 1:00 PM (continued)

Social History Narrative

Family History:
Family History

Problem	Relation	Age of Onset
• Diabetes	Father	
• Stroke	Father	
• Diabetes	Sister	

CC is diabetic ulcers both feet. Treatment thus far has included serial casting, IV antibiotics, weekly trimming. Last week he elected to ry no cast and be NWB. Despite this plan he arrived today in SHOES both feet.

PE:
Vital Signs:
Filed Vitals:

	09/28/16 1053
BP:	130/90
Pulse:	94
Temp:	98.2 °F (36.8 °C)

General: Well developed, well nourished. Non-acute distress.
Pyshyactric: Oriented to time, place and person. Alert. Mood and behavior appropriate for this visit.
Vital Signs:
Filed Vitals:

	09/28/16 1053
BP:	130/90
Pulse:	94
Temp:	98.2 °F (36.8 °C)

Head: Normocephalic, atraumatic. Vision and healing intact.
Neck: No obvious masses.
Chest: Respirations are not labored.
Right foot ulcer is plantar and centrolateral. Today it was measured at 27 X 32 mm Lower Extremity:
Left foot ulcer is under the 1st MT head. He has no great toe on this foot. Debrided with beaver blade and measures 5 X 5 mm.

With improvement over the last week he would now like to have the PICC line pulled.

A. Bilateral foot ulcers.
P. Cast on the left. I participated in application and checking of cast. Boney prominences were appropriately protected and cast appropriately molded.

Progress Notes - Progress Notes (continued)

Progress Notes by Rory A. McCoy at 10/6/2016 8:26 AM (continued) Version 1 of 1

Electronically signed by Rory A. McCoy at 10/10/2016 5:34 AM
Attribution Key
Attribution information is not available for this note.

Progress Notes by Stacy L. Calloway, MD at 10/10/2016 5:29 AM Version 2 of 2

Author: Stacy L. Calloway, MD | Service: (none) | Author Type: Resident
Filed: 10/10/2016 2:23 PM | Encounter Date: 10/5/2016 | Creation Time: 10/10/2016 5:29 AM
Status: Signed | Editor: Stacy L. Calloway, MD (Resident)
Related Notes: Original Note by Stacy L. Calloway, MD (Resident) filed at 10/10/2016 5:34 AM

CHIEF COMPLAINT: Regularly scheduled followup bilateral diabetic foot ulcers.

HISTORY OF PRESENT ILLNESS: This is a 45-year-old male who has been followed by Dr. Thomas in her clinic for bilateral diabetic ulcers of his feet. Last time in clinic we had placed a cast in the left side since he had been noncompliant with non-weightbearing status at previous visit. We encouraged him to continue to be non-weightbearing on the right side as it was not as severe as the left. He had previously completed a course of IV antibiotics as well.

PHYSICAL EXAMINATION:
General: The patient is awake, alert and oriented, in no apparent distress. He is well nourished and well developed.
Pulmonary: Nonlabored breathing.
Abdomen: Soft, nondistended.
Cardiovascular: Well perfused with brisk capillary refill.
Musculoskeletal: Evaluation of the left lower extremity shows ulceration measuring 0.3 x 0.4 cm on the plantar aspect of the foot. This is slightly larger than it was last week. The left side there is an ulcer on the 1st metatarsal head that is measuring 2.5 x 3.5 cm. This is also larger than it was at our last visit.

IMAGING: No imaging was obtained at this last visit.

ASSESSMENT: This is a 45-year-old male with bilateral diabetic foot ulcers. He has been treated in a cast and has been made non-weightbearing.

PLAN: It appears that both ulcers are getting slightly bigger. A cast was placed on the left foot today and a wet-to-dry dressing was placed on the right. He should continue to be non-weightbearing bilateral lower extremities and we will see him back in clinic next week to re-evaluate both of his ulcers.

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000156332
ADM 2/9/2017, D/C 2/9/2017

Progress Notes by Davenport, Jennifer Elaine, ANP at 2/12/2017 11:34 AM

Author: Davenport, Jennifer Elaine, ANP | Service: (none) | Author Type: Nurse Practitioner
Date of Service: 2/12/2017 11:34 AM | Filed: 2/12/2017 11:34 AM | Note Type: Progress Notes
Status: Signed | Editor: Davenport, Jennifer Elaine, ANP (Nurse Practitioner)

Clindamycin 300mg 1 po qid for 2 weeks
Doxycycline 100mg 1 po bid for 2 weeks
Inform patient of A1C and that he needs to avoid sugars and carbs. F/U with pcp.
Electronically signed by Davenport, Jennifer Elaine, ANP at 2/12/2017 11:34 AM

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000156302
ADM 2/13/2017, D/C 2/13/2017

Procedures by Davenport, Jennifer Elaine, ANP at 2/13/2017 2:43 PM

Author: Davenport, Jennifer Elaine, ANP | Service: (none) | Author Type: Nurse Practitioner
Date of Service: 2/13/2017 2:43 PM | Filed: 2/13/2017 2:52 PM | Note Type: Procedures
Status: Signed | Editor: Davenport, Jennifer Elaine, ANP (Nurse Practitioner)
Cosigner: Easom, Delilah, MD at 2/13/2017 4:28 PM

Mercy Wound Care & Hyperbaric Medicine
Ph. 479-314-2804; Fx. 479-314-2807

Wound Care Progress Note 2/13/2017

PATIENT: Craig A Shipp **AGE:** 46 y.o.
CSN: 151803017 **MRN:** E1402148166
Date of Birth:

Chief Complaint: Right diabetic foot ulcer

Craig A Shipp is a 46 y.o. male who presents for follow up of right diabetic foot ulcer. Patient is a previous wound clinic patient that was treated for a left diabetic foot ulcer. When last seen in April 2015, he had charcot deformity of right foot. He sought consultation at UAMS for charcot foot surgical treatment. Dr. Thomas performed tendon release of toes on left but no surgical reconstruction done on right. He has had an ulcer for over a year. He has had surgical debridement of wound. Complicated with cellulitis. It is unsure if he had osteomyelitis. He has had course of 12 weeks of IV vanco. There was a time that he was going to have amputation but imagining showed no osteomyelitis. This was in November. Wound had been open over entire width of plantar foot. It has gotten smaller but not closed. C/O large amount of drainage. Applying dry gauze today. No offloading. He has had been in cast several times. No HBO.

Diabetic and reports that CBG has been worsening while he was on IV abx. Non smoker. Uses chewing tobacco. No previous PVD. He does not work. He has used crutches to help offloading but does not use anymore.

Today, he reports that drainage drained through dressing after 1 day. Wound cx + for MRSA and mixed enteric flora. No fever or chills. A1C was significantly higher at 12.8%. ESR and CRP elevated. MRI ordered but pending scheduling. HBO approval in progress.

Past Medical History

Diagnosis	Date
• Diabetes *type II*	
• HTN (hypertension) *controlled with medications*	
• MDRO (multiple drug resistant organisms) resistance *Left toe MRSA*	4/10/14
• MRSA (methicillin resistant staph aureus) culture positive *right foot*	02/09/2017
• Neuropathy, peripheral	

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000156302
ADM 2/13/2017, D/C 2/13/2017

Procedures by Davenport, Jennifer Elaine, ANP at 2/16/2017 2:25 PM

Author: Davenport, Jennifer Elaine, ANP | Service: (none) | Author Type: Nurse Practitioner
Date of Service: 2/16/2017 2:25 PM | Filed: 2/23/2017 5:19 PM | Note Type: Procedures
Status: Addendum | Editor: Davenport, Jennifer Elaine, ANP (Nurse Practitioner)
Related Notes: Original Note by Davenport, Jennifer Elaine, ANP (Nurse Practitioner) filed at 2/16/2017 5:16 PM
Cosigner: Easom, Delilah, MD at 2/27/2017 8:42 AM

Mercy Wound Care & Hyperbaric Medicine
Ph. 479-314-2804; Fx. 479-314-2807

Wound Care Progress Note 2/16/2017

PATIENT: Craig A Shipp **AGE:** 46 y.o.
CSN: 151803141 **MRN:** E1402148166
Date of Birth:

Chief Complaint: Right diabetic foot ulcer

Craig A Shipp is a 46 y.o. male who presents for follow up of right diabetic foot ulcer. Patient is a previous wound clinic patient that was treated for a left diabetic foot ulcer. When last seen in April 2015, he had charcot deformity of right foot. He sought consultation at UAMS for charcot foot surgical treatment. Dr. Thomas performed tendon release of toes on left but no surgical reconstruction done on right. He has had an ulcer for over a year. He has had surgical debridement of wound. Complicated with cellulitis. It is unsure if he had osteomyelitis. He has had course of 12 weeks of IV vanco. There was a time that he was going to have amputation but imagining showed no osteomyelitis. This was in November. Wound had been open over entire width of plantar foot. It has gotten smaller but not closed. C/O large amount of drainage. Applying dry gauze today. No offloading. He has had been in cast several times. No HBO.

Diabetic and reports that CBG has been worsening while he was on IV abx. Hemoglobin A1C was 12.8%. He is not checking CBG. He has f/u with pcp 2/17. Non smoker. Uses chewing tobacco. No previous PVD. Normal TCOM and ABI. Wound bleeds well. Albumin was normal at 4.8. Insurance requires a pre albumin for HBO approval. Will order. He does not work. He has used crutches to help offloading but does not use anymore.

Today, he is doing well with complaints. Drainage still large amount but slightly decreased. Wound CX + for MRSA and mixed enteric flora. Tolerating clindamycin and doxycycline. Have received a large stack of medical records from UAMS. Will review.

Past Medical History

Diagnosis	Date
• Diabetes *type II*	
• HTN (hypertension) *controlled with medications*	
• MDRO (multiple drug resistant organisms) resistance *Left toe MRSA*	4/10/14

Signoff Information
Electronically Signed By: KELLI RIPPY, MD on 06/14/2017 at 05:07 PM.

Encounter Date	Examiner	Role	Chief Complaint
03/16/2017 04:41 PM	MUSTAIN, CATHERINE		Medications

Medcin Note
Craig A. Shipp, Sex: M, DOB: Encounter Date and Time: 3/16/2017 04:41PM, Examiner: Catherine L. Mustain, PA

Chief complaint
The Chief Complaint is: Medications.

Allergies and Adverse Reactions
No Known Allergies.

Signoff Information
Electronically Signed By: CATHERINE L. MUSTAIN, PA on 03/18/2017 at 08:17 AM.

Encounter Date	Examiner	Role	Chief Complaint
02/17/2017 01:42 PM	RIPPY, KELLI		Check up on Diabetes, Hypertension, and Cholesterol

Medcin Note
Craig A. Shipp, Sex: M, DOB: 11/11/1970, Encounter Date and Time: 2/17/2017 01:42PM, Examiner: Kelli Rippy, MD

Original

Chief complaint
The Chief Complaint is: Check up on Diabetes, Hypertension, and Cholesterol.

History of present illness
Craig A. Shipp is a 46 year old male.
Mr. Shipp is here today for follow up diabetes, hypertension, hyperlipidemia. His bp is upper normal today. He has struggled with diabetic foot ulcers and has had partial amputation of foot. Currently in wound care at Mercy wound care clinic and has been fighting that for nearly a year. He is due for labs. He did have an a1c done at wound clinic and it was 12.8. His a1c here in August was 6.8, so this is a dramatic increase. He does not think his diet changed all that much. They did not check lipids. He has not been checking his cbg's that frequently. He is taking his medication.

Current medication
Medication List Reconciled.
Gabapentin 400 mg capsule take 1 capsule by Oral route 3 times per day PT NEEDS APPOINTMENT.
MetFORMIN 500 mg tablet take 1 tablet by Oral route 2 times per day with morning and evening meals for diabetes.
GlipiZIDE 5 mg tablet extended release 24hr take 1 tablet (5 mg) by oral route once daily with breakfast.
AmLODIPine 10 mg tablet take 1 tablet by Oral route 1 time per day.
Lisinopril 40 mg tablet take 1 tablet by Oral route 1 time per day for blood pressure.
- Doxycicline
- clindamyacin

Past medical/surgical history
Reported:
Reviewed past medical history.
Medical: No previous hospitalizations. Previous hospitalizations UAMS 07/29/16-8/6/16 Foot Ulcer, UAMS 05/16 Foot Ulcer.
Legal Documents: Living will not on file, advance healthcare directive not on file, medical orders for life-sustaining treatment not on file, and DNR not on file.
Diagnoses:
Hypertension.
Diabetes mellitus
Surgical:
- Orthopedic surgery AMPUTATION OF LEFT GREAT TOE / JULY 12,2012 / MERCY FORT SMITH / SUDBRINK
- Orthopedic surgery Dr Ruth Thomas / UAMS Ortho / 6/29/15 / split toes and put in some type of wires to keep straight
- Neuroplasty with transposition of median nerve at carpal tunnel LEFT HAND SEVERAL YEARS AGO

Personal history
Social history unchanged.
Behavioral: No coffee consumption. Daily tea consumption was one cups per day. Not a former smoker. Chewing nicotine-containing substances.
Alcohol: Alcohol use a social drinker 6 PACK EACH DAY ON SAT AND SUN.
Drug Use: Not using drugs.
Home Environment: Lives with parents.
Education: The highest level of education achieved: 12 years completed.
Marital: Single.

Family history
Family history unchanged
Paternal:
Father
Hypertension
Diabetes mellitus
Stroke syndrome
Maternal:
Mother 78 years old.

Review of systems
Gastrointestinal: No diarrhea.

Physical findings
Vital Signs:
Vital Signs/Measurements Value Date
Tympanic membrane temperature 97.8 2/17/2017
RR 18 per min 2/17/2017
PR 108 bpm 2/17/2017
Blood pressure 140/90 mmHg 2/17/2017
Weight 232.4 lbs 2/17/2017
Body mass index 29.8 kg/m2 2/17/2017
Height 74 in 2/17/2017
Standard Measurements:
Standard Measurements: Value Date
Body surface area 2.3 2/17/2017
General Appearance:

SuccessEHS, Inc. makes no warranties or representations whatsoever regarding the quality, content, or completeness of information included in this report.

	Chloride, Serum				
	Carbon Dioxide, Total				
	Calcium, Serum	9.9	MG/DL	8.7-10.2	
	Protein, Total, Serum				
	Albumin, Serum				
	Globulin, Total				
	A/G Ratio				
	Bilirubin, Total				
	Alkaline Phosphatase, Serum				
	AST (SGOT)	31	IU/L	0-40	
	ALT (SGPT)	54	IU/L	0-44	H
	EGFR IF NONAFRICN AM	48	ML/MIN/1.73	>59	L
	EGFR IF AFRICN AM	55	ML/MIN/1.73	>59	L
	BUN/Creatinine Ratio	18		9-20	
	Sodium, Serum	135	MMOL/L	134-144	
	Chloride, Serum	94	MMOL/L	96-106	L
	Carbon Dioxide, Total	18	MMOL/L	18-29	
	Protein, Total, Serum	8.1	G/DL	6.0-8.5	
	Albumin, Serum	4.8	G/DL	3.5-5.5	
	Globulin, Total	3.3	G/DL	1.5-4.5	
	A/G Ratio	1.5		1.1-2.5	
Component Comments:	**EFFECTIVE MARCH 13, 2017 THE REFERENCE INTERVAL** FOR A/G RATIO WILL BE CHANGING TO: AGE MALE FEMALE 0 - 7 DAYS 1.1 - 2.3 1.1 - 2.3 8 - 30 DAYS 1.2 - 2.8 1.2 - 2.8 1 - 6 MONTHS 1.3 - 3.6 1.3 - 3.6 7 MONTHS - 5 YEARS 1.5 - 2.6 1.5 - 2.6 > 5 YEARS 1.2 - 2.2 1.2 - 2.2		Bilirubin, Total	<0.2	MG/DL
0.0-1.2			Alkaline Phosphatase, Serum	114	IU/L
39-117					

Result Comments: creatinine has bumped up again, ? if due to his infection and antibiotics. Have to stop metformin though and increase glipizide to 10 mg a day. Monitor his sugars and if still running high may need to increase that further or add a different agent. Repeat bmp in 2 weeks KR

Ordering clinician: Rippy, Kelli

02/17/2017 02/17/2017 83036 I10, E11.4, E78 A1C [IN-HOUSE] HEMOGLOBIN

Component	Value	Unit	Range	Indicator
A1C	13.0	mg/dl	0.0 - 7.0	H

Result Comments: way above goal, confirms that his sugars are not running normal. He may even need insulin. Have him check his cbg fasting each morning and about 1-2 hours after supper. Bring log by in 2 weeks when he comes in for lab so we can decide what to do KR

Order Comments: [(Clia waived test)]

Ordering clinician: Rippy, Kelli

08/16/2016 08/16/2016 83036 M86.37, I10, E11.4, E78, M14.67 A1C [IN-HOUSE] HEMOGLOBIN

Component	Value	Unit	Range	Indicator
A1C	6.8	mg/dl	0.0 - 7.0	N

Order Comments: [(Clia waived test)]

Ordering clinician: Rippy, Kelli

01/19/2016 01/19/2016 82044 E11.4 Microalbumin (in-house) dipstick

Component	Value	Unit	Range	Indicator
Negative	Other			
Microalbumin [In-House]	100	/mL	0 - 0	H

Result Comments: Results above Expected Range

Order Comments: [(Clia waived test)]100 (N 0.0) indicates renal manifestations.

Ordering clinician: MUSTAIN, CATHERINE L.

01/19/2016 01/19/2016 83036 E11.4 A1C [In-house] Hemoglobin

Component	Value	Unit	Range	Indicator
A1C	7.1	mg/dl	0.0 - 7.0	H

Result Comments: Results above Expected Range

Order Comments: [(Clia waived test)]7.1 (N <5.7) would recommend he make appointment with Pixie King to see if she can help him lower the A1c as well as cholesterol

Ordering clinician: MUSTAIN, CATHERINE L.

01/19/2016 01/19/2016 80061 E11.4, E78 Lipid (in-house)

Component	Value	Unit	Range	Indicator
TC	237	mg/dl	0 - 200	H
HDL	41	mg/dl	>40	
TRG	514	mg/dl	<150	

SuccessEHS, Inc. makes no warranties or representations whatsoever regarding the quality, content, or completeness of information included in this report.

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Procedures by Davenport, Jennifer Elaine, ANP at 2/23/2017 11:25 AM (continued)

Partners: Female

Other Topics	Concern
• Not on file	

Social History Narrative

Subjective

FSBS: Uncontrolled with A1C of 12.8% 190 this am
Fever: No
Chills: No
Nausea: No
Vomiting: No
Oral Intake: Good
Supplements:
Pain Control: Good
Presence of Pain: none

Objective

Review of Systems
History obtained from the patient
General ROS: negative for weight changes, fever
Endocrine ROS: positive for - skin changes and delayed wound healing
Cardiovascular ROS: negative for chest pain or dyspnea on exertion
Gastrointestinal ROS: negative for reflux, abdominal pain, change in bowel habits, or black or bloody stools
Musculoskeletal ROS: positive for - gait disturbance
Neurological ROS: positive for - gait disturbance and numbness/tingling

Physical Exam:

Visit Vitals

• BP	123/83 (BP Location: Left arm, Patient Position (BP): Sitting)
• Pulse	90
• Temp	97.2 °F (36.2 °C) (Oral)
• Wt	107.5 kg (237 lb)
• SpO2	96%
• BMI	30.43 kg/m2

General appearance: alert, in no distress, appears older than stated age
Extremities: no edema to bilateral lower legs. Decreased hair distrubution to distal legs
Pulses: 2+ and symmetric

Right plantar foot at arch with large ulceration
Wound base with red granulation tissue that is covered with bioburden
Large amount of callous Rolled wound edges

Procedures by Davenport, Jennifer Elaine, ANP at 3/2/2017 11:14 AM (continued)

4. Education will be provided for future wound prevention and closure of existing wound.

Long-term Goals: (due in 8 weeks)
1. The patient's wound will present with 100% viable tissue in 8 weeks
2. The patient's wound will demonstrate 80% closure and maturation of the newly healed tissue.
3. The patient and/or family will demonstrate 100% compliance with dressing changes and instructions to assist in wound closure.
4. Education will be provided for future wound prevention and closure of existing wound.
5. The patient/family members will be provided with handouts to allow 100% understanding of their wound care and healing issues to prevent future recurrence.
6. The patient will be measured for, fitted with and educated on compression garment wear/care, donning/doffing and edema/skin management prior to discharge.
7. The patient will be referred to an Orthotist, as needed, or returned to prior orthotic management and footwear to prevent reopening of wound.

Plan

Culture obtained right foot wound.
Right plantar foot wound debrided and silver nitrate for cautery in clinic: betadine periwound today, Maxsorb ag, exudry, dr bells, darco shoe with peg insert with pegs removed for pressure relief.
Return to clinic on Tuesday for dressing change and next Friday for provider visit.
Referral to Dr Calero infectious disease.
Please send copy of MRI results to Dr Thomas at UAMS in Little Rock.

Discussed MRI results. HBO still needed to salvage this limb threatening wound. He states that Dr. Thomas was reluctant to shave bone previously due to risk of infection. Other surgical option was amputation. He does not want to see orthopedist locally. Will request ID consultation to guide options of treatment re: abx recommendations. Offloading is a must. Recommend a walking boot to stabilize ankle. Patient refuses. Due to drainage, TCC not an option yet. Also, in the past, he was hard on TCC and cracked a few TCC.

Total Time: 20 minutes
Time Counseling: 10 minutes
Counseled on above

Jennifer E Davenport, ANP, 3/2/2017 11:14 AM

Electronically signed by Davenport, Jennifer Elaine, ANP at 3/4/2017 12:17 PM
Electronically signed by Easom, Delilah, MD at 3/4/2017 9:04 PM

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000197000
ADM 5/5/2017, D/C 5/5/2017

Procedures by Davenport, Jennifer Elaine, ANP at 5/5/2017 1:47 PM (continued)

Plan

Right 3rd toe. paint with betadine or g violet with each dressing change.
Right plantar foot wound debrided and silver nitrate for cautery in clinic :prisma today before maxsorb ag, exudry, bulky wrap, Charcot boot. Only have to use betadine at home if wound looks wet around it. Patient to change dressing every day.
Approve for Dermagraft. Pending
Return to clinic in 1 week.
Order supplies from Advanced Tissue if needed. Didn't get last order that should have been delivered this past Wednesday.

Advised patient to try and keep off foot more. Recommended crutches which he refuses. Discussed TCC but he refused to have the type of TCC that the clinic utilizes. Hopefully dermagraft will be approved soon because this is the best option for wound closure.

Total Time: 20 minutes
Time Counseling: 10 minutes
Counseled on above

Jennifer E Davenport, ANP, 5/5/2017 1:47 PM

Electronically signed by Davenport, Jennifer Elaine, ANP at 5/6/2017 4:10 PM
Electronically signed by Easom, Delilah, MD at 5/7/2017 9:17 AM

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000197000
ADM 5/12/2017, D/C 5/12/2017

Procedures by Davenport, Jennifer Elaine, ANP at 5/19/2017 1:51 PM

Author: Davenport, Jennifer Elaine, ANP | Service: (none) | Author Type: Nurse Practitioner
Date of Service: 5/19/2017 1:51 PM | Filed: 5/19/2017 4:22 PM | Note Type: Procedures
Status: Signed | Editor: Davenport, Jennifer Elaine, ANP (Nurse Practitioner)
Cosigner: Easom, Delilah, MD at 5/20/2017 9:36 AM

Mercy Wound Care & Hyperbaric Medicine
Ph. 479-314-2804; Fx. 479-314-2807

Wound Care Progress Note 5/19/2017

PATIENT: Craig A Shipp **AGE:** 46 y.o.
CSN: 156242463 **MRN:** E1402148166
Date of Birth:

Chief Complaint: Right diabetic foot ulcer

Craig A Shipp is a 46 y.o. male who presents for follow up of right diabetic foot ulcer. Patient is a previous wound clinic patient that was treated for a left diabetic foot ulcer. When last seen in April 2015, he had charcot deformity of right foot. He sought consultation at UAMS for charcot foot surgical treatment. Dr. Thomas performed tendon release of toes on left but no surgical reconstruction done on right. He has had an ulcer for over a year. He has had surgical debridement of wound. Complicated with cellulitis. It is unsure if he had osteomyelitis. He has had course of 12 weeks of IV vanco. There was a time that he was going to have amputation but imagining showed no osteomyelitis. This was in November. Wound had been open over entire width of plantar foot. It has gotten smaller but not closed. C/O large amount of drainage. Applying dry gauze today. No offloading. He has had been in cast several times. No HBO.

Diabetic and reports that CBG has been worsening while he was on IV abx. Hemoglobin A1C was 12.8%. He is not checking CBG. He has f/u with pcp 2/17. Non smoker. Uses chewing tobacco. No previous PVD. Normal TCOM and ABI. Wound bleeds well. Albumin was normal at 4.8. Insurance requires a pre albumin for HBO approval. He does not work. He has used crutches to help offloading but does not use anymore.

MRI showed no osteomyelitis. Extensive midfoot deformity may be related to Charcot joint with extensive chronic changes with fusions and severe osteoarthritis; Tenosynovitis posterior tibial tendon; Some soft tissue edema noted laterally small joint effusion tibiotalar joint.

Today, he returns for weekly follow-up. He has completed 30 HBO tx. No significant change. No further hyperbarics requested. He was placed on doxycycline and Flagyl last appointment due to ongoing drainage. Continues to have large amount of drainage. Dressing change to Betadine Packing at last visit to see if would help dry wound. Unfortunately, he has more maceration today. His been counseled to stay off of foot as much as possible But he has refused crutches. He is compliant with charcot boot and changing dressing at home daily due to Wound drainage. No fever or chills. He has began basal insulin but does not feel that it is improving. He called earlier this week and has agreed to seek second surgical opinion with Dr. Seiter.

Past Medical History:

MERCY WOUND CARE 7306 ROGERS
7306 Rogers Ave
Fort Smith AR 72903-4164

Shipp, Craig A
MRN: E1402148166, DOB: Sex: M
Acct #: 74000233131
ADM 5/26/2017, D/C 5/26/2017

Procedures by Davenport, Jennifer Elaine, ANP at 5/26/2017 1:53 PM (continued)

donning/doffing and edema/skin management prior to discharge.
7. The patient will be referred to an Orthotist, as needed, or returned to prior orthotic management and footwear to prevent reopening of wound.

Plan

Right 3rd toe: Paint with betadine with each dressing change.
Right plantar foot wound silver nitrated in clinic today: Paint periwound with betadine, endoform, hydrafera blue classic (put on dry, due to drainage), bulky wrap, Tubigrip, Charcot boot.
Change hydrafera when draining through. Change endoform every 3-4 days per drainage, may use ABD pad or Maxi pad.
Approval for Dermagraft - Pending
Return to clinic in 1 week.
Follow up with Orthopedic Surgeon for second opinion. Has apointment with Dr Kenneth Seiter 6/12/17 @ 8am.

Due to no improvement after 30 HBO treatments, do not feel that additional tx would be beneficial. Healing complicated by hyperglycemia, wound drainage, charcot deformity, etc. Would recommend shaving off of rocker bottom bone to decrease pressure and help with wound healing. Again patient reports that no surgical procedure recommended by Orthopedic Surgeon. Discussed second opinion with other local providers of Dr. Seiter or Dr. Clayton when he returns from military deployment. He has agreed and referral to Dr. Seiter is scheduled. He was instructed to stay off the foot as much as he can, however, this is an area of noncompliance. Patient was advised that without surgical intervention I do not feel that there is any possible limb salvage And he'll likely have below the knee amputation. He was instructed to go to the ER for any worsening signs of cellulitis or sepsis.

Total Time: 20 minutes
Time Counseling: 10 minutes
Counseled on above

Jennifer E Davenport, ANP, 5/26/2017 2:33 PM

Electronically signed by Davenport, Jennifer Elaine, ANP at 5/26/2017 2:33 PM
Electronically signed by Easom, Delilah, MD at 6/5/2017 12:02 PM

Discharge Summaries by Al-Ghussain, Emad A, MD at 6/21/2017 12:39 PM (continued)

Benign essential HTN
AKI (acute kidney injury)
Hyponatremia

Hospital Course: The patient is a 46-year-old white male with history of diabetes, diabetic Charcot foot on the right side with a chronic ulcer on the plantar surface, who has been followed by Podiatry and the Wound Clinic at Mercy. The patient underwent biopsy including bone by Podiatry on 06/12/2017. After the procedure, he noticed worsening swelling and gradually increasing erythema. He was seen by the Wound Clinic on 06/16 and doxycycline was added because of MRSA infection. The culture shows that the MRSA is resistant to tetracycline. The patient came into the emergency room today because of increasing swelling and erythema of the whole ankle and foot. He has drainage from the ulcer. The pathology report of the ulcer shows no evidence of osteomyelitis. The wound culture showed MRSA and mixed Gram-negative rods. He had some fever recently. No nausea or vomiting. No shortness of breath or abdominal pain.
Patient was admitted to the hospital. Started on IV antibiotic. Patient was followed in the hospital by the wound care team. Patient condition improved. The podiatrist Dr.Sieter , was not available he was out of town. Patient was feeling better and was assisting on being discharged. Patient was given instructions about wound care and activity. Patient was instructed to follow-up with the podiatrist and wound clinic within a week.

Discharge Exam:

BP 106/69 (BP Location: Right arm, Patient Position (BP): Supine) | Pulse 76 | Temp 98.1 °F (36.7 °C) (Oral) | Resp 17 | Ht 6' 2" (1.88 m) | Wt 108.4 kg (239 lb) | SpO2 92% | BMI 30.69 kg/m2

General appearance: alert, in no distress
Lungs: clear to auscultation bilaterally, normal respiratory effort
Heart: normal rate, regular rhythm, normal S1, S2, no murmurs, rubs, clicks or gallops
Abdomen: Soft, non-tender. Bowel sounds normal. No masses, no organomegaly.
Extremities: intact distal pulses
Neurologic: Peripheral neuropathy

Discharge Diagnoses:
Principal Problem:
Cellulitis of right foot
Active Problems:
Diabetic ulcer of right foot
Charcot foot due to diabetes mellitus
DM (diabetes mellitus), type 2
Benign essential HTN
AKI (acute kidney injury)
Hyponatremia

Medications:

Progress Notes - Progress Notes (continued)

Progress Notes by Ruth L. Thomas, MD at 6/27/2017 4:17 PM (continued) Version 1 of 1

No current facility-administered medications for this visit.

Allergies: No Known Allergies
Social History:
Social History

Social History	
• Marital Status:	Single
Spouse Name:	N/A
• Number of Children:	N/A
• Years of Education:	N/A

Occupational History	
• disabled	Not Employed
•	Disabled

Social History Main Topics	
• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No
• Drug Use:	No
• Sexual Activity:	No

Other Topics	Concern
• Not on file	

Social History Narrative

Family History:
Family History

Problem	Relation	Age of Onset
• Diabetes	Father	
• Stroke	Father	
• Diabetes	Sister	

CC is continuing ulcer plantar surface of the right foot in the midfoot region. He has been followed by wound clinic in Ft. Smith and has been unable to heal. Tells me that a Dr. Seiter did a biopsy of the bone directly through the present ulcer and it did not show osteomyelitis, but this was followed by a huge infection of the foot which has just finally cleared. Dr. Seiter tells him that he can do a reconstruction of the foot and eliminate the deformity and prevent re-ulceration.

PE:
Vital Signs:
Filed Vitals:

06/27/17 1303

Progress Notes - Progress Notes (continued)

Progress Notes by Ruth L. Thomas, MD at 6/27/2017 4:17 PM (continued) Version 1 of 1

BP: 106/68
Pulse: 99
Temp: 98.2 °F (36.8 °C)

General: Well developed, well nourished. Non-acute distress.
Pyshyactric: Oriented to time, place and person. Alert. Mood and behavior appropriate for this visit.
Vital Signs:
Filed Vitals:

06/27/17 1303
BP: 106/68
Pulse: 99
Temp: 98.2 °F (36.8 °C)

Head: Normocephalic, atraumatic. Vision and healing intact.
Neck: No obvious masses.
Chest: Respirations are not labored.
Right foot Lower Extremity:
Skin: Ulcer is still present unfer the mid portion of the mid foot. There is surrounding callus. The rest of the foot is into infected today but he shows pictures that show a very significant infection of the foot.
Musculoskeletal: There is no movement of the midfoot joints.

Imaging: Prominent bone under the midfoot/ulcer

A. Chronic non-healing diabetic ulcer. No evidence to support osteomyelitis, but chronicity very upsetting for the patient.

P. Consider BKA.
Pt wishes to proceed July 31.

Electronically signed by Ruth L. Thomas, MD at 6/27/2017 4:23 PM
Attribution Key
Attribution information is not available for this note.

Orders

UAMS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

UAMS Hospital
4301 West Markham Street
Slot #524
Little Rock AR 72205
Inpatient Record

Shipp, Craig A
MRN: 003128944, DOB: , Sex: M
Adm: 7/31/2017, D/C: 8/3/2017

Discharge Summaries - Encounter Notes (continued)

Discharge Summaries by Chad B. Willis, MD at 8/3/2017 10:34 AM (continued) Version 1 of 1

11/11/1970

Admit date: 7/31/2017

Discharge date and time: 08/04/2017

Admitting Physician: Ruth L. Thomas, MD

Discharge Physician: No att. providers found

Admission Diagnoses: S/P BKA (below knee amputation) unilateral, right [Z89.511]

Discharge Diagnoses: S/P BKA (below knee amputation) unilateral, right [Z89.511]

Admission Condition: good

Discharged Condition: good

Indication for Admission: S/P BKA (below knee amputation) unilateral, right [Z89.511]

Hospital Course: Craig A Shipp was admitted on 7/31/2017 11:31 AM and underwent Right Below Knee Amputation on 7/31/17. This procedure was tolerated well and there were no surgical complications. The post operative hospital course was uneventful. By the day of discharge, an adequate diet to maintain hydration and nutrition was tolerated without nausea or vomiting. Pain was well controlled with oral pain medication with good bowel/bladder function and the patient was ambulate without difficulty. Mr. Shipp was discharged home in good condition on hospital day 3.

Consults: none

Significant Diagnostic Studies: Prior MRI

Treatments: IV hydration, Antibiotics including Vancomycin and Zosyn, Analgesia with narcotics, Anticoagulation with LMW heparin and surgery as described above.

Discharge Exam:
Please see daily progress note for physical exam findings on the day of discharge

Disposition: Home

Patient Instructions:
Discharge Medication List as of 8/3/2017 10:00 AM

START taking these medications

Details

-- Reprint -- Reprint -- Reprint --

Arkansas ACC
Southwest AR DCC Canteen

Shipp, Craig A.
Customer Number: 660878
Housing Location: UNK/UNK

REGULAR RECEIPT

Item	Qty	Price
Heritage clear deodorant soap	1 @ 0.77	0.77
Ex.- Twin Blade Razor	2 @ 0.24	0.48
Quick Shave Gel, Clear	1 @ 2.11	2.11
Pre-stamped Envelopes	10 @ 0.53	5.30
Hard Time Mug	1 @ 2.07	2.07
Sm. Laundry Bag	1 @ 3.91	3.91
PLASTIC UTENSIL KIT	1 @ 0.20	0.20
Chili NO Beans, Brushy Creek	3 @ 1.95	5.85
IDAHO 4 CHEESE MASH POTATOES	3 @ 1.80	5.40
Baker's Harvest Saltine Crackers	1 @ 2.22	2.22
Chips, M/L Whole Shabang	2 @ 1.89	3.78
Corn Chips-Hot&Spicy, Cactus	1 @ 2.55	2.55
Ramen Creamy Chick	6 @ 0.28	1.68
Ramen Roast Beef	6 @ 0.28	1.68
Ramen Texas Beef	6 @ 0.28	1.68
RAMEN NOODLES HOT & SPICY VEG	6 @ 0.28	1.68
Toaster Pastry- Strawberry	1 @ 2.57	2.57
Coffee, Columbian Freeze	2 @ 3.21	6.42
Hot Cocoa Mix, Keefe	1 @ 2.03	2.03
Hawaiian Punch SF Juicy Red	1 @ 1.49	1.49
Mt Dew	6 @ 0.70	4.20

Banquet Chicken Nugget		
	1 @ 3.88	3.88
Mushroom Cheeseburger		
	1 @ 2.25	2.25
Chkn Buffalo Sandwich		
	1 @ 1.84	1.84
FC Jal. Charbroil & Cheese		
	1 @ 2.49	2.49
Sub Variety		
	1 @ 2.18	2.18
RB Meat Trio Pizza		
	2 @ 2.49	4.98
BB Bean & Cheese Burrito		
	4 @ 1.06	4.24

Subtotal	79.93
Sales Tax	4.40
Total	84.33

March 22, 2016 12:48:25 PM

X_____

Shipp, Craig A.

-- Reprint -- Reprint -- Reprint --